Occidental Medical Times.

Vol. IX. AUGUST, 1895. No. 8.

THE VAGINAL SECRETION AND ITS IMPORTANCE AS REGARDS PUERPERAL FEVER.

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Read before the San Francisco County Medical Society.

Much has been written within the last five years upon the possibility of self-infection of puerperal women, by bacteria contained in the vaginal secretion. In Germany, particularly, where the large lying-in hospitals afford extensive material for investigation, this subject has been given attention. The work in this field is so recent, that the text-books on obstetrics have little or nothing to say on the question; and it is only in the journal literature that information can be found. The present article is but a compilation from these journals, a review of what has been discovered up to date. Döderlein, of Leipzig, was the first to make the claim that a by no means small percentage of the puerperal infections must be attributed to microörganisms flourishing in the vagina; which, by internal examination or manipulation, are carried from the vagina into the freshly injured birth-channel. His monograph on the subject was published in 1892. In this, he made a sharp distinction between normal and pathological vaginal secretion. Normal secretion is a whitish, crumbly material, of the consistence of curdled milk, without mixture of mucus; its reaction is intensely acid, and bacteriological examination shows in such secretion the almost exclusive occurrence of one form of bacillus, whose vital properties are characteristic. Pathological secretion is of a yellowish-green color and creamy consistence, frequently scattered with small bubbles of gas, and frothy or mixed with tenacious yellow mucus; its reaction is generally weakly acid, but not rarely neutral or alkaline; and it contains the most different forms of microörganisms, bacilli and cocci, in large number. From normal vaginal secretion, Döderlein succeeded in making a pure culture of a bacillus whose action is strongly acidifying to the medium in which it grows, and whose influence is distinctly antagonistic to other bacteria, especially to the pathogenic staphylococci and streptococci. These bacilli are always markedly disseminated in normal secretion, but not to be found at all in pathological secretion, or only in small number; while on the other hand, pathogenic germs could never be demonstrated in normal secretion.

Döderlein examined 195 women either pregnant or in labor, with reference to their vaginal secretion, and his practical conclusion was that the danger of internal examination, whether during pregnancy or in labor, depends upon whether normal or pathological secretion is present in the case. In pregnant women, with normal secretion, examination with aseptic fingers carries no dangers of infection; on the contrary, isolated pathogenic germs that get into the vagina during pregnancy, quickly perish. But pathological secretion, in which pathogenic germs are already present, or in which those introduced during pregnancy find favorable conditions for development, becomes a considerable source of danger to the woman in labor, if by frequent internal examination transportation of germs to the uterus is favored.

Burguburu, [1] who carried on his investigations, in part, simultaneously with Döderlein, published his results a little later. He examined the vaginal secretion of twelve healthy pregnant women, nine primiparæ and three multiparæ. He did not attempt a division into normal and pathological secretion such as Döderlein made, but found, in two cases, the staphylococci and once the streptococci present, although none of these women had previously been examined *per vaginam*. Burguburu was inclined to attribute to the vaginal secretion considerable importance in the origin of puerperal fever.

Williams, of Johns Hopkins University, [2] published in July, 1893, the results of his investigations of the vaginal secretion in fifteen pregnant women not previously examined internally. He made his investigations after Döderlein's report was published, and holds the latter's distinction between normal and pathological secretion to be correct. The normal secretion, intensely acid, contained the vaginal bacilli described by Döderlein; but, in eight cases in which cultures from the secretion showed pathogenic germs, the reaction was changed so that it became very weakly acid or neutral.

Stimulated by Döderlein's report, Burckhardt, assistant at Fehling's Clinic, in Basel, took up the investigation of vaginal secretion and published his results in the fall of 1893, in a lengthy and exhaustive paper. [3] Burckhardt set himself the task of answering the following questions: (1) Can a sharp distinction be made between normal and pathological vaginal secretion? (2) What is the relation between normal and pathological secretion and a normal and pathological puerperium? (3) Of what nature is the influence of clinical examination with each secretion? Burckhardt took vaginal secretion from 150 pregnant women for examination, but as 34 of these had not yet come to labor at the time he wrote his paper, he excluded them from his statistics, leaving 116 cases on which to base his discussion.

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[1] Archiv für experimentelle Patholog. und Pharmakolog., Bd. xxx, S. 463.
[2] American Journal of Medical Science.
[3] Archiv. für Gynäkologie, Bd. XLV, Heft 1.

As regards his first question, he found that 69 presented a secretion undoubtedly normal—that is, milk-white in color, intensely acid and containing a great preponderance of Döderlein's vaginal bacilli. Pathological secretion, for the most part of smeary yellow color, weakly acid or neutral reaction and with a preponderance of pathogenic bacteria, he found in 32 cases. Of the remaining 15, which did not agree in all respects with either the normal or pathological secretion described by Döderlein, 4 were proved by the microscope, to belong to the normal group and 6 to the pathological. Thus, out of 116 cases, there remained but 5 in which the secretion could not be distinctly classified; one of these, apparently normal, showed only a moderate amount of the Döderlein bacilli, and also streptococci chains; 2 contained staphylococci, though normal in appearance; aad the 2 others, with otherwise normal conditions, showed cocci of the most different kinds and vaginal bacilli in like number. In the main, Burckhardt concludes that Döderlein is right in his differentiation between normal and pathological secretion.

The second question, "What is the relation between normal and pathological secretion and normal and pathological puerperium?" was answered by careful observation of the course of childbed in each woman whose secretion had been examined. Of the 73 cases with normal secretion, 56 passed through the puerperium without any disturbance, but the other 17 suffered from puerperal infections—a morbidity of 23.3 per cent. Of the 38 cases with pathological secretion, 19 had a normal puerperium, but the other 19 did not—a morbidity here of 50 per cent. There thus appears to be a distinct influence of the bacterial contents of the vaginal secretion upon the course of childbed, probably brought about by direct infection of the freshly injured birth-channel; and the danger of a feverish puerperium is decidedly greater with a pathological than with a normal vaginal secretion.

The third question may be put more simply now in this form: How do the germs residing in the vagina get into the uterus? Most probably, answers Burckhardt, through internal examination of the woman, and corresponding to this the danger of infection grows proportionately greater with repeated examinations.

Krönig, assistant to the University Woman's Clinic at Leipzig, was the next to take up the investigation of vaginal secretion. His paper stating his results was published in January, 1894.[1] Krönig took issue with Döderlein in several particulars. In the course of 300 examinations he said he had never found the secretion either neutral or alkaline in reaction; and he believed that even in so-called pathological secretion the acidity was too great to allow the growth of the streptococcus pyogenes. He also claimed from his investigations that the vaginal secretion of women never examined *per vaginam*, no matter whether such secretion appeared normal or pathological, never contained septic germs—except the gonococcus. Krönig did not find that the bacilli described by Döderlein were the sole cause of the acid reaction in normal vaginal secretion; on the contrary, he had cultivated from pathological secretion a form of coccus that had the property of causing acid reaction by its growth. Krönig also denies that the acidity of vaginal secretion is due to germs of any sort, but says the natural reaction of the secretion is acid, and that germs colonize in it only because the acid culture medium agrees with them; that the acidity is primary, the germs are secondary. Krönig's findings as to the relation of normal and pathological secretion to the course of the puerperium did not agree with those of Burckhardt. Among 221 pregnant women, 104 had pathological and 117 normal secretion. Among the former, 31 or 29.8 per cent. had an abnormal puerperium; while among the latter, with normal secretion, 36 had disturbance of the puerperium—30.8 per cent. Among these pregnant women 103 had never been examined *per vaginam;* of these, 59 had pathological secretion and 44 normal. Of the 59 pregnant women with pathological secretion, 18 or 30.5 per cent had a feverish puerperium; while of the 44 with normal secretion 20 or 45.3 per cent had a feverish puerperium. From these figures Krönig concludes that the condition of the vaginal secretion during pregnancy has very little to do with the puerperium.

The most startling statements on this subject are those published very recently by Walthard, of Berne.[2] He announces that the vaginal secretion of pregnant women never examined internally not rarely contains the germs of puerperal fever—streptococci, staphylococci, gonococci, and the bacterium coli. In 27 per cent. of all women examined he found streptococci in the vaginal secretion, which could not be distinguished from those of puerperal fever. Among 100 vaginal secretions he found only 14 that corresponded to the normal secretion according to Döderlein. Furthermore, among 22 cases that were normal by macroscopical and microscopical examination and by reaction, he found 7 that on culture contained streptococci; and from this he concludes that without culture experiments the vaginal secretion cannot properly be divided into normal and pathological; also that the acid reaction does not entirely destroy streptococci.

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[1] Centralblatt für Gynäkol., No. 1, 1894.

[2] Archiv für Gynäkologie, Bd. xlviii, Hft. 2.

The genital canal of a woman in the last month of pregnancy, who has never been examined internally, can be divided, according to Walthard, into a portion containing bacteria and a portion free from bacteria. The portion free comprises the upper part of the cervical canal, the uterus, and the tubes; the boundary lies in the middle part of the cervical mucous membrane, whether the vaginal secretion be clinically normal or not. The influence of the vaginal secretion calls forth leucocytosis on the cervical mucous membrane at the external os, and by phagocytosis the quantity of the microorganisms is decreased. In normal birth the cavity of the uterus does not become infected by the natural passages; for the germs in the infected vagina are reduced to a minimum after rupture of the membranes, by the influence of the liquor amnii. The cavity of the puerperal uterus is protected from spontaneous immigration by a column of mucus in the cervical canal, which the lochia cannot dissolve.

Menge, of Leipzig, reviews Walthard's work in an article published in the *Centralblatt für Gynäkologie*, March 23, 1895. He agrees with the latter's views, which he accepts as a confirmation of his own previously expressed. He believes that no germs from the vaginal secretion, except the gonococcus, can thrive in the cervical canal; that even if they find their way into the cervix, they obtain a footing there only when tissue lesions exist, through which they can enter. If the tissues are sound, all bacteria, except the gonococcus, perish under the influence of the formed tissue elements, and the tissue juices surrounding and filling the cervical cavity. Menge fixes the boundary between the germ-invaded territory and that free from germs, in the cervix, corresponding to the point of transition from acid vaginal to alkaline cervical secretion. The cervical canal, in his opinion, has the power of self-purification from bacteria, depending not only on a mechanical, but also on a bactericidal activity of factors still unknown. He believes with Walthard that the leucocytes also play a part in this process of purification of the cervix.

The most recent paper on this subject of the vaginal secretion has just been published by Krönig in the *Centralblatt für Gynäkologie*, April 20, 1895. Not content with his previous assertion that the vaginal secretion does not contain pathogenic germs, he has been attempting by culture experiments to determine what sort of germs those are that exist so abundantly in the secretion. Krönig announces that he has found one microörganism, which, through the frequency of its occurrence and by its characteristic behavior, deserves especial mention. This is a coccus form, which arranges itself in rows, 12 to 20 lying together, and which microscopically does not differ in any way from the streptococcus found in puerperal fever. But this germ is always anaërobic, and cannot be made to grow in air; in thus differing essentially from the streptococci found by Walthard. This coccus, too, is not virulent; Krönig injected it beneath the skin and into the peritoneal cavity of dogs, without result. It therefore is without influence upon the course of childbed. Krönig, in his paper, has studied and describes several other coccus and bacillus forms that he has cultivated from vaginal secretion. Most of them are anaërobic, and require an acid culture medium. Like the coccus mentioned, they play no part in the production of puerperal fever.

Here, then, the controversy rests at present; and until more investigations are made the question cannot be settled. Nevertheless, it should be borne in mind that the preponderance of the evidence thus far presented favors the possibility of puerperal self-infection by the vaginal secretion.

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STRICTURE OF THE RECTUM, AND ITS TREATMENT.

By Emory Lanphear, M.D., Ph.D., St. Louis, Mo., Professor of Orthopedic Surgery and Clinical Surgery in the Woman's Medical College.

Stricture of the rectum, both non-malignant and cancerous, is of much more frequent occurrence than formerly supposed. Since physicians are becoming less timid about making rectal examinations and more familiar with the pathological conditions of the lower portion of the large intestine, we are learning how common stricture is. It having been determined that a stricture of the rectum exists in a given case, the first question that must be decided is whether the disease producing it is malignant or not; and the second question to be answered as soon as the first is settled is, What is the proper treatment?

Malignant Strictures.—After a considerable experience in the treatment of carcinomata of the rectum, I have come to these conclusions: (1) All cancers of the rectum demand inguinal colotomy. The earlier it is done the better. (2) Cancerous growths may be excised whenever they are not fixed in a mass of infiltrated tissue, and when the chain of glands running from the rectum toward the liver is not involved. This point is determined when colotomy is performed. The method of removal to be preferred is by resection of the sacrum, as suggested by Kraske. (3) Linear proctotomy is never justifiable in cancerous stricture except when patients positively refuse colotomy, and death is imminent from obstruction of the bowel. (4) Inguinal colotomy, properly performed, is attended with no danger; is a means of prolonging life for many months, and is not nearly so disagreeable to patients as generally taught. (5) A small proportion of cases of cancer of the rectum can be cured by early extirpation.

Non-malignant Strictures.—In the text-books we find the following methods of treatment proposed and described: (1) Dilatation. (2) Incision. (3) Electrolysis and *raclage*. (4) Excision; and (5) Colotomy. And under the heading "Dilatation," are grouped: (*a*) forcible dilatation under anesthesia; (*b*) gradual dilatation by means of bougies. The advocates of the latter measure are numerous and enthusiastic. Gant, for example, goes so far as to advise letting patients pass their own bougies. The objections to gradual dilatation are: It does not cure; it must be kept up indefinitely; it is dangerous. The rectal wall is sometimes abnormally fragile, and the peritoneum often dips very deeply into the pelvis. I have been compelled to operate for one perforation of the rectum; the first indication of trouble was the abdominal pain following an enema that failed to come away in proper time. Some hours later, upon the supervention of peritonitis, I made an abdominal section to close the rectal rent and to check the progress of the inflammation, but the patient was already in collapse, and died upon the table. On account of the unsatisfactory results obtained by gradual dilatation, I have entirely abandoned it in favor of operation. Forcible dilatation, with a Pratt's speculum, does fairly well for true annular or simple stricture, when the patient will not permit operation; it has to be frequently repeated.

Excision and electrolysis (Nos. 3 and 4, *supra*), have little to commend them. The treatment of non-malignant stricture, therefore, may be reduced to two operative procedures: (*a*) Proctotomy; and (*b*) Colotomy.

Colotomy is only to be employed in inoperative cases: those too high in the bowel for posterior proctotomy, those of too long standing to expect cure, etc., and cases demanding temporary arrest of the flow of feces over the site of rectal operation.

Proctotomy is, in every way, the best treatment to be adopted; the only other line which can be compared with it being gradual dilatation. Over this linear proctotomy possesses these advantages: (1) It relieves at once. (2) It cures some cases. (3) It places all others in such a condition that the occasional passage of a bougie prevents a return of the trouble. (4) It does not keep up an irritation for long, thus producing a real increase of the strictured area.

Proctotomy may be made either as an external proctotomy or an internal division of the stricture. External proctomy has many supporters high in authority, such as Kelsey, Van Hook, and Allingham; but division of the sphincter is extremely liable to be followed by permanent incontinence of feces, as I have learned to my disgust in two of my own cases, while it does not afford one bit better drainage or present a particle less danger than the form of internal proctotomy I employ. I have, therefore, discarded external linear proctotomy entirely.

Internal proctotomy is easily performed, as follows: Under complete anesthesia the sphincter ani is widely dilated—completely paralyzed temporarily—by slow and extreme stretching with a Pratt speculum. When the anus is well opened a small speculum is passed through the stricture, if possible, and opened to a moderate extent, putting the tissues on a stretch; then the constricting bands are cut toward the sacrum until a healthy base is reached. If this does not allow the speculum to open widely and with ease, other incisions are made toward the sides of the pelvis. When the stricture is thus perfectly divided the blood is cleared away by irrigation and the wounds dried. Much iodoform is dusted in and the rectum tamponed tightly with strips of iodoform gauze packed around a hard rubber tube passed considerably above the stricture and allowed to protrued through the anus.

This dressing is allowed to remain 72 hours, when, after its removal, the rectum is thoroughly washed out with weak sublimate solution, and the bowel loosely packed with gauze, which is permitted to remain until forced out by a movement of the bowels. Healing is prompt and satisfactory. The results in my experience exactly corroborate Mathews' statement, "If the operation is done effectively, I have never seen the necessity of employing a bougie afterwards for the purpose of dilatation."

I will report only one case—the first operation of this kind I ever performed:

J. P——, of Indianapolis, Ind.; 40 years of age; came under my care in April, 1889. Aside from one or two attacks of facial erysipelas she had always had the best of health; no history of tuberculosis, cancer or syphilis. She appeared to be in perfect health, weighing 158 pounds, though of only medium hight, of florid complexion, good appetite, and cheerful disposition. For many years she had had a stricture of the bowel located 1½ inches above the external sphincter, and extending for more than an inch upward. This had been treated by bougies for a number of years, but for more than two years she had neglected passing the "instrument of torture" as she called it. For some months constipation, or rather extreme difficulty in passing feces, had been very troublesome, and an evacuation of the bowel could only be effected by prolonged straining after a saline had been taken; and for three or four weeks almost complete obstruction had existed. I operated with the assistance of Dr. W. H. Burgesser, of Papinsville, Mo. There was an unusual amount of bleeding, especially from a lateral cut, but it was easily controlled by the packing. She made a speedy and satisfactory convalescence. More than six years have passed and she has never had a bad symptom, nor has she ever passed a bougie since. Need any comment be made?

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POSSIBLE ORIGIN AND NATURE OF THE SYPHILITIC POISONS.

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Read before the San Francisco Medico-Chirurgical Society.

If Mr. Gadgrind were alive to-day, and, favoring us with his presence, should have deigned to listen to the papers that have been read at these meetings, no doubt he would have been delighted at the array of facts—hard, cold facts, that have been presented for our consideration. But there are other things in this world beside actual facts—namely, possible facts; and it is to some of these that the title of this paper refers.

The term syphilitic poisons is used, rather than the older term syphilitic virus, for two reasons: First, because the former conveys an idea of multiplicity, while the latter does not; secondly, because in this article the manifestations of secondary syphilis are considered to be the result of the physiological action of a definite chemical substance, some of whose characteristics will be mentioned.

For the sake of completeness, rather than of relevancy to the subject under discussion, it may be added that syphilis is considered to begin with the initial lesion, the chancre, and to end with the termination of the secondary manifestations; that the cirrhotic processes which sometimes follow syphilis are sequelæ; and that the gummatous processes, which sometimes follow syphilis, are not syphilitic at all. It is also assumed to be true that the physiological action of drugs is governed by a law, and that this law is substantially as follows, other things being equal: Those substances having the same structural formula or chemical constitution, have the same physiological action. To those who have closely studied the chemical arrangement of the great host of synthetical remedies that have been lately given to the medical world, nothing can be plainer than the essential truth of this view.

Proceeding upon this basis to the consideration of syphilitic poisons, the observer's attention is attracted by a most significant point—the striking similarity of the symptoms of secondary syphilis as manifested in different individuals. These are too constant, and bear too close a family resemblance to be produced by agents differing widely in their nature. The polyadenitis, the eruption, the pharyngitis, the anemia, occurring so constantly can mean only one thing, viz., the same substance, or group of substances, that, circulating through the body, causes such peculiar changes.

What can be the nature of these substances? Are they organic or inorganic? The answer to the latter question seems to be clear. They are organic. No known inorganic substance, even remotely, duplicates the action of the poison of secondary syphilis. Of course, individual symptoms are more or less well imitated, but that peculiar group of symptoms that makes up the clinical picture of secondary syphilis cannot be produced by inorganic material. Whatever may be the nature of these substances, one characteristic is that they will not easily dialyze. This is shown by the fact that none of the physiological secretions, nor excretions, will, when inoculated into healthy individuals, produce syphilis; and also by the fact that secondary syphilitics are immune to the disease.

The recent experimental work in diphtheria has but proven again what Pasteur had taught long before—large doses of certain substances cause disease, while comparatively minute doses confer immunity to that disease. In the light of this knowledge is it unreasonable to suppose that, in primary syphilis, the small but growing colonies of microörganisms at the site of infection, and in adjacent lymph glands, may elaborate in a few days enough of these substances to produce immunity, but not enough for several weeks to cause physiological action? If these substances were dialyzable, and were consequently promptly eliminated, it is difficult to see how such immunity could occur. Again, it is claimed by various authors, and probably their claims are supported by their experience, that the immunity toward a second infection persists through life. In the explanation of the cases that are examples of this long-continued immunity, it is most reasonable to assume that minute traces of the poisons of the secondary stage still remain in the circulation because of their stability, and because of their non-dialyzable character.

Their presence, even in very small quantity, would appear to render the body an infertile soil for the growth of the microörganisms.

There are other facts which appear to give color to this idea. Take an illustration from clinical experience. A healthy woman becomes impregnated. After gestation has progressed for 7 or 8 months the husband contracts syphilis, and promptly communicates it to his wife. Pregnancy proceeds, labor comes on, a healthy child is born, and is duly nursed at the breast, yet persists in remaining in perfect health, as far as syphilis is concerned. This may be explained in the following way: Suppose that the husband at the seventh or eighth month inoculated the wife during intercourse, and that the syphilitic germs found a congenial soil and propagating, grew into the lymphatics and veins, were carried to the lymphatic glands in the groin and in the pelvis, in each of which places new colonies were started. With the enormous increase of living, but foreign material, there resulted the elaboration and absorption into the circulation of substances, which, increasing in quantity, soon began to produce their physiological action. During this time could the child have been affected? It has had no direct communication with the mother. Nutrition and oxygenation have been carried on mainly by dialysis. Now, if the syphilis poisons, which were circulating in the mother's blood, and were producing their physiological action upon her in the way of eruption, pharyngitis, iritis, etc., were practically non-dialyzable, and because of this found their way into the child's circulation in minute quantities only, may not this have been the reason of the child's immunity? May not the non-dialyzability of the secondary syphilis toxin be the explanation of the not well known Sykes' law?

Just the converse of this law is Colles' law. In brief, the latter is, that a syphilitic child cannot inoculate its own mother with syphilis. Why not? Because a minute quantity of the non-dialyzable syphilis poison escaped from the feto-placental circulation into that of the mother, and produced in her an immunity to the disease. Of course this immunity is not absolute in every case—neither is it so in variola, rubeola, scarlatina, etc.

On the other hand, there are the children who are born covered with the eruption of secondary syphilis. At first thought this seems utterly irreconcilable with Sykes' law, yet it is not so, for the latter may not have had time to come into play, or may have been rendered inoperative because of a sudden and overwhelming dose of the toxin administered during intrauterine life. The literature on the subject of vaccinal syphilis permits no doubt to be entertained as to the result that may follow the inoculation of a healthy subject with the blood of one suffering from secondary syphilis.

When a child is born with a secondary eruption already upon its skin, it may be confidently assumed that inoculation took place at least some days, if not some weeks, or even months, previous to its birth. How could such infection have taken place? Now, if we regard the foregoing explanation of Sykes' law to be the true one, the child should be incapable of being affected! How, then, can we account for its condition? Immunity, it must be borne in mind, is not absolute. Immunized animals may be made to succumb to the disease they are strongly proof against, by administering excessive quantities of the poison to them. This may be the case in syphilis, especially if the disease be contracted by the mother early in, or before, the pregnancy. In such an event, even though the poison may be practically non-dialyzable, yet its constant presence on one side of the dialyzing membrane (the uterine capillaries) for from three to nine months, may result in a considerable amount passing through; and though at first producing immunity, yet the increasing amount finally would produce disease. This gives an idea of the degree of dialyzability, as it were, that the toxin possesses, for during the last two months of pregnancy it has been found infection of the child very rarely occurs.

There is also another explanation. When we consider the danger of injury to which a pregnant woman is exposed, from falls, blows, etc., from the outside, as well as from the furious kicks which the fetus administers from the inside, it is not improbable that small lesions between placenta and uterus sometimes ensue. These would result in direct blood-communication between mother and child. If the former should have secondary syphilis, would there not be great danger of vaccinal syphilis? The secondary syphilis toxin is practically non-dialyzable. Another characteristic of the toxin is that it forms new and innocuous compounds in the body with some of the metals, notably with mercury; less so with gold and copper, when they are administered in therapeutic doses. It is difficult to account for the so-called specific action of these remedies on any other hypothesis. Whether the result is due to the direct chemical action of the metals upon the syphilis toxin, or, as some writers have earnestly maintained, to the indirect action of the remedies as a foreign body, so stimulating cell action that the change occurs, can only be surmised.

A fact that appears to point to the theory of direct chemical action, is that mercury is one of our most reliable reagents for the detection of albumin, and also for that of the vegetable alkaloids, in solution.

Whether the action of the drug be direct or indirect, nothing can be more certain than that it does very speedily accomplish the destruction of the toxin, and that it does not very speedily accomplish the destruction of its source. A few days' treatment may cause the disappearance of the eruption, and in a few weeks all of the secondary symptoms may be absent, yet from two to four years' treatment is necessary for the thorough eradication from the body of the source of the toxin. It is in harmony with the results of clinical observation to consider that mercury completely changes the character of the toxin, and that the specific action of the mercury in secondary syphilis is dependent almost, but not entirely, upon that change.

A well-known case that seems to be an example of this power of mercury to effectually destroy the toxin and yet not remove its source, is known to most writers on syphilis as "Thurman's Case." Two syphilitics were married. Both had been treated, apparently recovered, and never afterward, while under observation, manifested any symptoms of syphilis. Seven children were born, became covered with syphilitic eruption and died. Pregnant for the eighth time, the mother was brought under the influence of mercury. The child was born healthy and grew up sound. Pregnant for the ninth time, the treatment of the mother was repeated, a healthy child resulted, who remained well. Pregnant for the tenth time, treatment was neglected. A child was born, seemingly well at first, who developed a syphilitic eruption and died after six months. In her eleventh pregnancy the mother again took mercury. A healthy child was born who remained well.

Another characteristic of the syphilis toxin is a rather peculiar one. It appears to select certain structures upon which to expend its action, and in this choice it is imitated in a measure by atropine and to a lesser degree by cocaine. There is wide difference between the action of the toxin and that of atropine—where the latter causes a motor or sensory change the former causes, as a rule, a growth of cells. Atropine acts upon the fever center; the toxin causes fever. Atropine acts upon the nerve endings in the iris; the toxin causes iritis. Atropine causes a reddening of the fauces and a feeling of dryness in the throat; the toxin causes a pharyngitis. Atropine often produces an eruption upon the skin; the toxin also produces an eruption. Atropine has a well defined anesthetic property; the toxin produces in some cases a well marked anesthesia and analgesia.

It will be noticed in this connection that the action of the atropine is a transitory one, while the action of the toxin is more permanent and irritating. It is also evident that both act by affecting nerve tissue, though the atropine seems to select sensory and motor nerves, while the toxin appears to influence the trophic fibres. Possibly, as is the case with atropine, it is the nerve endings that are acted upon, and it may be because of this fact that the new syphilitic cells never become organized. However, it is not intended by this comparison to show that the toxin is an atropine-like body. Atropine is an alkaloid, and whatever the nature of the toxin may be, it is certainly not that of an alkaloid.

The toxin is probably a proteid. Proteids are very complex bodies having large molecules. There is no special reason why these large molecules may not contain one or more alkaloids as well as other structures within themselves. Indeed, it is not unlikely that the alkaloids of plants are held in this manner during growth. The syphilitic proteid may contain as one of its constituents a body built up on the atropine type. Why not? Presumably this toxin (proteid) is produced by a living vegetable within the body. This vegetable, the syphilis microörganism, is miscroscopic in size of course, but that does not alter the case a particle, for size is only comparative.

Suppose that this microscopic vegetable, being beside a stream of blood in a lymphatic gland, elaborates its alkaloid and then dies. The dead vegetable is washed away in the blood stream and dissolved like any other particle of food or poison. The alkaloid, incorporated into and forming a part of the large albuminous molecule, has an action of its own, and if the alkaloid is sufficiently prominent its action will to a certain extent modify the action of its host.

It is not at all improbable that some process very similar to this takes place in syphilis. The albumin molecules from the cadavers of the dead syphilis microörganisms may be the agents that cause the eruption, anemia, fever, pharyngitis, etc,, and yet their action may be guided in a special manner by the alkaloids entering into their composition. An illustration of this modifying action is found in the case of some of the alkaloids. The radicle benzoyl, for instance, forms only a small part of the molecules into which it enters, yet it gives to them the property of local anesthesia, a property which they did not before possess.

Another and well-known characteristic of the toxin, to which reference has already been made, is that in some manner it causes the proliferation of young cells. Whether or not this effect is produced by the toxin irritating the terminals of the trophic nerves, this much is certain, that the cells grow and do not organize.

Prince A. Morrow, writing on the subject of "Syphilis of the

Skin," says: "It will simplify our conception of syphilis to recognize that its numerous lesions, no matter how diverse they may appear, all possess essentially the same histological character, and owe their origin to the same pathological process. Microscopical investigation shows that every form of syphilitic lesion from the earliest and most superficial to the latest and most profound, consists of an infiltration of round or embryonal cells in the connective tissues of the different organs. These embryonal cells constitute the essential element of every syphilitic lesion. Even in the erythematous eruption which expresses the lightest and most transitory touch of syphilis, there is in addition to the hyperemia, a slight cell infiltration permeating and surrounding the walls of the blood vessels of the papillæ and corium."

A different aspect of the subject presents itself. The same writer continuing says: "It is a pathological law which admits of no exception that these infiltrated cells never become organized into connective tissue, but undergo involution through absorption, or disappear by a process of suppuration." Now in the face of this statement, and the truth of the statement every one will admit, how are we able to explain those cases of hereditary syphilis which are, so to speak, a veritable bundle of connective tissue—cases with viscera so interlaced with connective tissue as to be almost cartilaginous in hardness?

Plainly, the toxin which causes the cells to grow, but never allows them to organize, and the toxin which causes the cells to grow and become organized, are two separate and distinct poisons.

That they are related, and perhaps closely related to each other, is evident, as both have a syphilitic origin, and both stimulate cell growth; but that they are identical, is inadmissible. Producing different physiological effects, they must necessarily differ chemically.

With the result of the action of the tertiary toxin, we have but to contrast the result of the action of alcohol upon the tissues, to note the resemblance. Cirrhosis, as a rule, denotes the action of alcohol just as surely as ashes denote the action of oxygen. It is not argued that the cirrhosis of alcoholism and of tertiary syphilis are identical, but it is contended that they are of the same nature.

The conclusion reached by this line of reasoning, is that the substance or substances that produce the cirrhosis of syphilis probably are hydrocarbons, more or less closely related in chemical structure to ethyl. The most probable source of these alcohols of tertiary syphilis, is in the breaking down of the molecule of the secondary toxin. The latter, as already mentioned, is probably a large molecule belonging to the proteids, constructed by vital action of microorganisms, and composed, in part, at least, of hydrocarbons of the ethyl type, grouped together in such a manner as to resemble the structure of atropine. This huge molecule, obtained by the body from the dead microörganisms, is broken down by the natural forces of the system, and the simple substances from which it was built up, are liberated. These simple substances are the hydrocarbons to which reference has already been made. Under conditions not well understood, but which appear to prevail, especially during intra-uterine life, these hydrocarbons produce their physiological action. This action results in the diffuse, interstitial visceral affections. Not very rarely the same action occurs in adults, and as a rule, results in the development of such disorders as general paralysis and tabes dorsalis.

422 Twenty-fourth street.

INFANT FEEDING.

By M. W. Ward, M.D., Woodland, Cal.

Read before the California Northern District Medical Society.

In the artificial feeding of infants it is certainly true that the preparation agreeing perfectly with one child may not, and very often does not, meet the requirements of another of the same age, and apparently under the same conditions. Infants as well as adults have idiosyncrasies of which we can never be certain without personal acquaintance, and sometimes experiment. They have differences in original strength, heredity, environment, and constitution that we can know only by investigation in each individual case. To make a success of infant feeding we should study each individual case, and then let the indications be our guide.

With the laity the great delusion has ever been that in medicine there can exist such a thing as a cure-all. On this the patent remedy man feeds and fattens. Much akin to this is the search for an artificial food that will nourish all babies, and the assertion of each manufacturer of infant food that he has just that article. Many doctors, I am sorry to say, give undue encouragement to the manufacturers who perpetrate a delusion and rob the people unnecessarily. Through laziness or want of intelligence, or both, Dr. A—— prescribes for his patient a patent medicine, a secret remedy, of which he knows nothing, and thus becomes an abettor of fraud. Dr. B—— prescribes a proprietary medicine, a non-secret remedy, put up in the form of a shotgun prescription, but made for doctors only. He thus becomes not only a mere figure-head whose prescription is already written and compounded for him without any reference to his particular patient, but he also lends himself as an advertiser and introducer of a medicine that will soon become in the hands of the public a patent medicine to all intents and purposes with the diseases for which it can be used written on the bottle and sold over the counter by blind leaders of the blind. Dr. C—— prescribes, as a matter of habit, some particular prepared food made by the manufacturer for the feeding of infants. What does he do for the parent who raises his baby on this food, even with success? He causes him to expend fifteen to twenty dollars a month unnecessarily; and that is not the only injustice, as we shall see later.

Our duty in prescribing is certainly plain: (1) To know the natural history of the disease in hand. (2) To know the action of the remedies that we use as scientifically demonstrated. (3) To know the peculiarities and condition of the person to be treated. (4) To prescribe for that particular case. Our best friends are the home pharmacist and the home cook. Our art is to apply the particular remedies to the particular case, and theirs is to prepare them *secundem artem*. The physician should study the action of foods as well as the action of drugs. This is most imperative in the treatment ot children, for with them the indication usually is to support.

In this paper I can deal only with generalities. The great bsaal fact in all infant feeding is this: Most infants thrive best on mother's milk. For untold ages the infant stomach has been adapting itself to the proper digestion and appropriation of human milk, and it is manifestly better fitted to digest that than any other food. We should advise, then, that all infants be nursed till such time as nature indicates a change of diet—which she does by a good showing of teeth. The mother's milk does not at all times nourish the child properly. The mother, through overwork, disease, or fits of passion, may render her milk so unfit for her infant that a substitute must be found for it. Besides this, some women are unable to furnish enough milk, and some cannot furnish any at all. A reliable authority has stated that one-third of the mothers of San Francisco cannot nurse their offspring. In the country districts and small towns we do not meet with so large a proportion, still the failures are many. Some of these we all know are wilful—the misguided mother being more solicitous about her form than the welfare of her offspring; her relation to society, than her relation to her home.

Practically, then, we as physicians have to devise ways and means for nourishing a large and increasing army of *commonwailers*. Deprived of their natural food, what is the best artificial food that we can devise? Evidently that which most nearly resembles the natural one—milk of some sort, modified so that it is as nearly like human milk as possible.

Of the hundreds of advertised infant foods, all, except one or two, contain starch in greater or less quantity. Starch as food should not enter the infant's stomach before the teeth are well formed, for the simple reason that previous to this the diastatic action of his salivary, pancreatic, and intestinal juices is almost *nil*. The starch will not be digested, and any great quantity can act only as an irritant.

Dr. Leeds, who has made extensive analyses of patent infant foods, has grouped them all into three classes: (1) Farinaceous foods. (2) Malted or Liebig foods. (3) Milk foods.

The first and oldest of these contain 70 to 80 per cent. starch; examples are Ridge's food, Blair's, Hubbell's, Robinson's and Imperial Granum. Ridge's food for infants has produced more cases of rickets in England than any other cause. There, 341,000 infants die yearly for want of mother's milk, one-fifth of the mothers being unable to nurse their offspring. In our country 400,000 succumb each year from imperfect feeding. Our stale and starchy shop foods kill more infants than alcohol does adults. Their glittering advertisements divert thousands of mothers from the paths of nature, and are an unwise and unnecessary drain upon the pockets of the fathers. The best of them are directed to be mixed with milk, in which case, the milk does the nourishing and the advertised article gets the credit.

A little starch-water added to cow's milk often acts well in holding the casein in a finely divided state, and thus preventing large tough curds. It mechanically honey-combs the curd, as it were, thereby rendering it more accessible to the gastric-juice; more like the curds of human milk. This starch-water can be prepared fresh, in the kitchen, with little or no cost or trouble, in the shape of rice-water, barley-water, etc., which will do the work even more satisfactorily than the starchy shop-foods. It is fresh and sterile, and the proportions and varieties are directed by the physician to suit the condition, as well as the age, of the child in hand.

The second class are those in which the starch has, to a greater or less extent, been converted into dextrine and sugar; examples are, Mellin's food, Horlick's, Hawley's and Lactated food. These are directed to be added to milk or milk and water. They are suitable to a weaker digestion than are the first class, perhaps; but they are inferior to the home-made "flour ball" that any house-wife can make with a few suggestions. In it, the starch is converted into dextrine alone. This will separate the curd better than the manufactured article; it is just as digestible, and the sugar can be added as needed and in known quantities. The third class comprises those foods to which the milk has already been added during the process of manufacture; examples are, Nestle's food, Anglo-Swiss, Gerber's, Carnrick's Soluble food and Lactopreparata, Horlick's Malted Milk, etc. These are directed to be mixed with water only, and are supposed to supply an infant food corresponding in nutritive value to human milk. One of these contains 45 per cent. dried milk, 45 per cent. dextrine and 10 per cent. sugar of milk, and is partly predigested, thus fitting it for very weak digestions.

Some of these are very good foods, but like all the rest, they are deficient in fat, and hence, more or less cream should be added when using them. Any of these foods can be at times, useful, provided we employ them temporarily for the special case; but it is too much like prescribing patent medicines and ready-made prescriptions. Laziness or non-intelligence lies at the bottom of the whole habit of encouraging the use of proprietary medicines and foods. All the proprietary infant foods are simply modifications of cow's milk, or intended to modify cow's milk, and this explains the success that attends the use of any of them.

If the milk of the mother or of a wet nurse is not available, the next best food for us to advise is cow's milk. It is everywhere accessible, cheap and efficient, and only needs the knowledge and skill that any physician ought to possess to direct its preparation for the case in hand.

Human milk varies in composition; its maximum of proteids has been found to be five times the minimum and the maximum of fats and salts three times the minimum, but it contains all the essentials necessary for the nutrition of the infant. As it comes from the breast, it is sterile and warm, like the food cooked for adults.

Cow's milk, used for infants, should be fresh, from a healthy cow, and one whose food at the time does not disturb her digestion, like green alfalfa or green corn. This milk also varies according to the breed, age, food, and health of the animal; but that of an ordinary cow (not a Jersey or Alderney) always contains more casein and less sugar than does human milk. This difference does not disturb the disgestion of some infants who will do well on pure, fresh cow's milk; but it is perhaps best in all cases, as it is imperative in some, to modify its composition so as to approximate human milk. This can be done by adding water and sugar and some starch water to prevent tough curds, and also cream, if the milk is poor, and lime water, if it be acid. In other words, examine the particular milk as well as the particular child, and adapt the milk to the strength and condition of the child to be treated.

Mothers adhere rather persistently to three mistakes in feeding babies: (1) They give the food too concentrated. (2) They give it too frequently. (3) They give it in too great quantities. These are mistakes of the head, certainly not of the heart; for their great fear is that the baby will starve. Thousands of babies, therefore, are stuffed to death where one is starved to death.

In estimating concentration, they compare it with the food of adults, rather than with human milk, which is a watery thin fluid that they know very little about. Very few babies get water enough to stimulate the gastric juice and to flush the sewers of the system. As to frequency, they do not consider the need of rest, or that regularity ought soon to be established with the natural rythm of the other functions. Regarding quantity, a child's stomach at birth can hold little over an ounce; if given more, it vomits it up or suffers in consequence; how foolish then, to "run it over."

During the first two months the stomach develops in size very rapidly, then more slowly till the sixth month, and then more rapidly till the tenth month. An average quantity would be:

First month, 1 oz. every 2 hours, or 10 oz. in 24 hours.
Second month, 2 oz. every 2 hours, or 16 oz. in 24 hours.
Third month, 4 oz. every 3 hours, or 24 oz. in 24 hours.
Sixth month, 6 oz. every 3 hours, or 36 oz. in 24 hours.

After this gradually increase the amount at a feeding, and decrease the number of feedings, observing regularity at all times.

In December, 1893, I prescribed the following preparation for a baby six weeks old, with whom the mother's milk, for some unknown reason, failed to agree, and various preparations had failed to nourish it, till the child was a mere crying skeleton. The parents lived on a farm, but were afraid of cow's milk. I ordered mixed each morning after milking:

Fresh milk, ½ pint.
Rice water, ¼ pint.
Milk sugar, 2 tablespoonfuls.
Boiled water, q. s., 1½ pints.

All to be put into a whisky bottle, on which I had marked the measures with a file for their future guidance. This mixture was then to be heated in a vessel of water till the water boiled, and then to be corked with cotton, and put in a cool place for the day. Every two hours three ounces were warmed in a clean nursing bottle and fed to the child.

The proportion of milk was to be gradually increased as the child's stomach was able to bear it, which was to be tried every few days. The proportion was one of milk to two of water; and this nourished the child well, but for over two months afterward it could not be increased without causing trouble. The amount at a feeding, however, was gradually increased, and the preparation was soon made both night and morning.

It seems to me that the only safe rule is to begin with the milk, even too dilute, and then to gradually feel our way up, watching the effect carefully till the normal standard is reached. The weight, as well as the age, of the child should be kept in mind in finding the standard. A baby weighing 6 to 8 pounds takes an ounce at a feeding, that is about $\frac{1}{100}$ of his initial weight; hence, if he were a 12-pounder to begin with, he would require two ounces at first. Weighing every two or three days is the only true and scientific method of testing the nutrition. A baby should gain one ounce or more every day for the first four months.

All bottles used should be sterilized frequently, and water used for diluting should be boiled. If the milk is boiled its taste is ruined; but it has been found that a temperature of 155° F. will destroy the ordinary milk germs and not injure the milk in any way. After the fifth or sixth month flour-ball, in one or two teaspoonful doses, can be added, two or three times a day. This, if boiled long enough, is changed into dextrine, which all babes like, and which is very nutritious. Mellin's food, instead of flour-ball, can be used if desired. One feeding for a six-months' old child would be for example:

Milk, 9 tablespoonfuls.
Cream, 1 tablespoonful.
Hot water, 2 tablespoonfuls.
Flour-ball, 1 teaspoonful.

If milk of one particular cow does not agree, then try another before abandoning fresh milk.

The next best food to try is Malted Milk; next, a good brand of condensed milk for a short time, but diluted much more than is directed on the can, say 1 to 20 to begin with, or the amount of sugar will be too great. Condensed milk is safer than the dairy milk in cities or larger towns.

If the child is seized with a diarrhea, all milk, starchy or sugared foods should be stopped and egg-albumin water substituted till the worst stages are past. I have used this in the strength of the white of one egg to 6 oz. of water, with a little salt added, and found it to almost work miracles. The egg should be well strained, but not beaten, ($\frac{1}{3}$ of a Fairchild's peptonizing tube can be added if necessary), mixed with the water and taken cold from a nursing bottle. This will prevent fermentation in the alimentary tract, especially if it be first well cleared by a dose of the submuriate. The child will soon tire of this food, however, and then Malted Milk may be tried for a while; but the father's pocket-book will soon tire of this, so get back to cow's milk as soon as practicable. Test the milk and give written directions to prepare it. After a severe attack of diarrhea, the child's digestive powers are weak, hence, its food should be more digestible and should be given in smaller quantities and oftener than in health.

It is a mistake, however, to suppose that the digestive powers, like all others, cannot be weakened by inaction and strengthened by action. The habitual use of predigested foods is as pernicious as the use of those that are indigestible. In the child we want development as well as growth and this cannot be obtained by one extreme any more readily than by another. As the child grows better his food should gradually approach the healthy standard. To test digestion watch the stools for curds and hyperacidity. Saponified fats are sometimes mistaken for curds, but they are at once detected by their solubility in alcohol. His indigestion should be rectified before the later and more marked signs appear—such as diarrhea, regurgitation, hicough, foul-smelling or clayey stools, or convulsions. These latter may or may not require medicine, but they certainly do indicate a change in feeding.

Constipation is often due simply to a deficiency in the amount of fat in the food. A certain amount of surplus fat is always found in the napkins of babies who live on mother's milk, and we know that the addition of cream or oatmeal water to cow's milk often acts kindly in overcoming constipation. A surplus of cane sugar, milk sugar, or even molasses, will do the same, but, perhaps, at too great a risk. It is certain, however, that the human alimentary canal is adapted to and requires a certain amount of indigestible material in the food—not so much as the herbivora, whose bowels are always loose, nor so little as the carnivora, which are always constipated, but a happy mean between these extremes.

When the child is well enough developed to digest starchy foods, which is not usually before the twelfth month, give him bread and milk, oatmeal gruel well done, rice and milk pudding, and then soft boiled eggs and stale bread crumbs, and later meat and potatoes, and teach variety in eating.

The artificial feeding of infants is becoming a more serious problem every year, from the increasing number of mothers who, for one reason and another, do not nurse their offspring. Our duty to humanity is first to encourage nursing; teach the mothers that no hand-fed child can be so well nourished as one fed from the fount of nature, all glittering advertisements notwithstanding. If nursing for any reason is found impracticable or impossible, then our plain duty is to prescribe a suitable food, in just as intelligent and conscientious a manner as we would prescribe a drug for a patient.

SUPRAPUBIC CYSTOTOMY FOR THE EXTRACTION OF A VESICAL CALCULUS, WITH ABLATION OF A PORTION OF THE MIDDLE LOBE OF THE PROSTATE, IN A PATIENT AGED 83 YEARS AND 7 MONTHS.

By L. BAZET, M.D., San Francisco, Cal.

The present case is that of a man on whom I operated in 1890; he was relieved of his pains for four years. They recurred after that time; he was operated on again, and he died after the second operation.

The patient complained of pain all along the penis; he was unable to pass urine without the aid of a catheter; the quantity was small and voided with pain. There were no hereditary conditions. His health, up to October 12, 1888, had been good, when he began to have hypogastric, lumbar and testicular pains, the right testicle being congested and enlarged. Four days afterwards he was seized with very acute pain in the hypogastrium, which lasted three hours, and was accompanied by retention of urine. Partial relief was given by the catheter, so that in a week he returned to work and continued at his occupation for six months. After that attack, his desire to urinate became more frequent, especially at night when lying on his back, he micturated with effort and pain; the stream being weak, with no projectile force. There were constant erections during the night.

All these symptoms became aggravated in the month of November, 1890, when, having caught a cold, the pains and retention of urine returned, with repeated violent attacks of chills and fever. The patient presented himself at the Polyclinic for treatment, and the following was the result of the examination: Deep seated pain in the prostatic region, with shooting pains in the lumbar region, the perineum, and the glans, and pains extending down both lower extremities to the heels. The pains were intensified by passing the catheter and by rectal examination. Rest brought no amelioration; night and day the pains continued; the passage of urine was so difficult and so intensely painful that the patient uttered the most heartrending cries; in fact to such an extent, that the proprietor of the house where he lodged was obliged to have him removed. The urine, at that time, was turbid, viscous and purulent. There was no pain on palpating either the hypogastrium, the perineum, the testicles or the kidneys.

Under the application of 2 per cent. cocaine solution, the bladder was examined; the explorator having passed the membranous portion, would not enter the bladder in the median line; it could only enter by one of two grooves, to the right and left. The prostatic urethra, therefore, formed two **V**-shaped grooves, leading into the bladder. In exploring the latter, I discovered at the *bas fond*, a calculus about 3 centimeters in diameter, and movable in all directions. The heart sounds were clear, and there was no arcus senilis or sclerosis of the radial arteries, notwithstanding his age. The pleura and lungs were healthy. The digestive organs were disordered by the constant irritation of the nervous centers, caused by vesical pains; tongue dry; no appetite; bowels constipated. There was no action of the skin; patient very emaciated. *Diagnosis*: Vesical calculus with hypertrophy of the middle lobe of the prostate.

The question, now, was: how to act? Was it better to crush the stone, and so avoid a traumatism, which, in so old a man, might be a very serious matter, or would it be advisable to perform suprapubic cystotomy, remove the stone and ascertain whether or not something could be done to facilitate or reëstablish the free passage of the urine? I decided on surgical intervention for the following reasons: there was painful cystitis, indicating inflammation of the muscular coat of the bladder; there was also an obstruction, due to hypertrophy of the prostate. By operating, the bladder would be put at rest and the prostatic region would not be subjected to an inevitable series of congestions, caused by the catheterization necessitated during and after lithotrity.

The operation was agreed on, and was performed on the 11th of December, 1890. The bladder was opened by the suprapubic vertical incision, using Peterson's rubber bag, at present rarely employed. The walls of the bladder were hypertrophied, measuring over one centimeter in thickness. A phosphatic calculus 3¼ centimeters long and 1¾ centimeters thick was removed. The middle lobe of the prostate was hypertrophied and belonged to that variety called "chicken rump" by the French surgeons. It spread out like a fan in front of the neck of the bladder and rested like a valve against that orifice whenever an attempt was made to micturate. A **V**-shaped incision cleared the vesical orifice without hemorrhage. The bladder was drained by Perier's tubes for five days, the cavity of Betzius was also drained for the same period. A few points of catgut suture for the deep layers and silkworm sutures for the superficial ones completed the operation. The wound healed in five weeks and the patient was discharged in the following condition: No pain, no catheterization required, natural micturition every three hours, urine clear.

The patient remained in good health until the fall of 1894, and in January last, again called at my office for relief, and begged of me to operate on him again. The painful symptoms had returned with increased exacerbation. I proposed castration which he refused, giving me as his reason that having derived a real benefit from the suprapubic operation he would not consent to a different method. If, however, it did not prove satisfactory, he would submit to castration.

On the 3d of February, at the German Hospital, Poncet's operation was performed, with the object of creating a hypogastric meatus; the middle lobe of the prostate was found obliterating the vesical neck as in 1890; the right lobe of the prostate, being also very much enlarged, compressing and reducing the lumen of the prostatic urethra. The vesical neck was raised considerably above its normal level, thus creating a *bas fond* for residual urine. The operation lasted half an hour. Notwithstanding the short time the patient was under anesthesia, and the good care he received, during and after the operation, he died twelve days later of urinary intoxication.

Phelan Building.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal.,
HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal., and
WM. FITCH CHENEY, B.L., M.D., Adjunct to the Chair of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal.

Parasites in Carcinoma of the Uterus.—VON MULLER has examined 21 cases of uterine cancer with reference to the contents of the carcinoma cells. In one case of carcinoma of the posterior lip, he observed three large cyst-like bodies, with a clear, glistening membrane that would not stain, which he describes in detail, and of which he gives illustrations. Smaller cysts are also portrayed, with their contents and the empty cyst capsules. Furthermore, von Müller observed in the case mentioned other bodies, not encysted; intracellular. In his opinion, these are parasitic ameboid organisms. The cysts, he thinks, represent permanent forms of the intracellular amebæ; but, positive proof as to the correctness of this view cannot be given by a fixed preparation, but only by observation of the living tissue, or by pure cultures.—*Archiv. f. Gynäkolgie*, Bd., XLVIII, Hft. 2.

The Treatment of Rupture of the Uterus.—This was one of the subjects for discussion before the German Society for Gynecology, at their meeting in Vienna, June 5-7, 1895. Papers on the subject were presented by FRITSCH and SANGER. Fritsch laid down the rule that with threatened rupture, the woman must be delivered as quickly as possible, and in whatever way that takes up least room in the birth canal. With vertex presentations, perforation and extraction with the cranioclast gives the best chance for the life of the mother; with transverse presentations, an attempt at version is justifiable only in case the child be living, and then, under deep narcosis. With a dead child, eviscerating operations are always to be made. If rupture is diagnosed and the child is in the abdominal cavity, it must be removed by laparotomy as quickly as possible. If the child is partly in the uterus and partly in the abdominal cavity, it may be extracted by the vagina, if extraction appears easy, under favorable surroundings; with severe, persistent hemorrhage, or with difficulty of extraction, laparotomy should be performed. Fritsch agrees with Leopold, that the only certain method to stop severe, protracted bleeding from the torn uterus is suture, by way of the abdomen, after laparotomy. It is not the uterine wound, but the wound outside the uterus, in the parametrium, that gives the most blood; and neither tamponade nor compression, nor both, will answer in certain cases, to check the hemorrhage. If hemorrhage has ceased spontaneously for several hours, and the pulse has grown better, the case should be treated with opium and absolute rest. Neither washing out of the vagina nor flushing of the peritoneal cavity by the vagina, is permissible.—*Centralblatt f. Gynäkologie*, June 22, 1895.

Indications for Total Castration by the Vagina.—The tendency at the present time is to do more and more pelvic surgery through the vagina and less through the abdomen. The vaginal route has been commended chiefly by PÉAN, SEGOUD, DOYEN, and RICHELOT. Another name frequently connected with this method of operating is that of JACOBS, of Brussels. The latter was invited by the American Gynecological Society to come to the United States and present his views before the Society at their annual meeting in May. His paper was entitled the "Indications for Total Castration by the Vagina." These indications he laid down as uterine cancer, fibroids of the uterus, extra-uterine pregnancy, total genital prolapse, the inflammatory diseases of the appendages, the chronic and incurable diseases of the appendages and of the uterus, and the diseases of the uterus after abdominal operation. The main argument was on the advantages of removing inflamed and suppurating appendages *per vaginam* instead of by laparotomy. Jacobs claims better results for the vaginal operation, especially from drainage downwards, less shock to the patient, and shorter convalescence, no abdominal cicatrix to give rise to hernia, and better health following the operation. Jacobs reported 403 cases on which he had operated by the vagina, with 12 deaths—a mortality of 2.9 per cent. In the lengthy discussion elicited by the paper, it seemed to be agreed that the vaginal mode of operating is more difficult than the abdominal; and as regards the results attainable opinions varied widely.—*American Gynecological and Obstetrical Journal*, June, 1895.

The Symphyseotomies of the United States.—ROBERT P. HARRIS has collected all the cases in which symphyseotomy has been performed in the United States, and finds there have been 74 operations up to May 1, 1895. Of these 74 women 10 died, and of the children 18 were lost. It is found that cesarian section is less fatal to children, but far more fatal to mothers. The danger to the mother in symphyseotomy does not lie so much in the pubic section as in injuries produced upon the urethra, vagina, and uterus in the forcible delivery of the fetus by the forceps, and the forcing open of the symphysis by the passage of the head under traction. Harris says that in Vienna the capabilities of the forceps for doing injury have been demonstrated to such a degree as to have reacted against symphyseotomy, in favor of cesarian section. The general mortality of symphyseotomy in all countries, taken collectively, is 34 in 303, or over 11 per cent. In the United States so far it is 10 in 74, or 13.5 per cent.—*American Gynecological and Obstetrical Journal*, June, 1895.

Flatulent Colic in Infants.—ERNEST SANSOM, of London, remarks that very few infants escape from manifesting some symptoms of this disorder. It often occurs in an infant at the breast, before it has become habituated to the new order of things which obtains after its birth; but much more frequently and more severely it occurs in artificially fed children. The pains associated with flatulence make the child extremely irritable, and its cry, contraction of the limbs, distortion of the face, are all indicative of suffering. The most effective immediate treatment is the administration of an aromatic, which stimulates the muscles of the stomach and bowel to expel the flatus. One of the most efficient remedies is the spirit of nitrous ether, of which 10 drops may be administered in a teaspoonful of water. The most useful prescription which the author has used consists of 2 grains each of powdered rhubarb and bicarbonate of soda, and 3 minims each of fetid spirit of ammonia and spirit of nitrous ether, given in one teaspoonful of dill-water three times a day. It should be remembered that flatulence is a symptom, and these measures are simply palliative.—*International Medical Magazine*, April, 1895. [I have frequently used for flatulent colic in infants a mixture of equal parts of Holland gin and liqueur anisette, of which the dose is 20 drops in a teaspoonful of water given every 15 minutes until relief is obtained. Rarely are more than two doses required. The mixture is a pleasant one to take, and infants seem to like it. The anisette is a French liqueur, made in Bordeaux, and is far superior to any other preparation from the anise seed.—W. F. C.]

SURGERY AND ANATOMY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal.,

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Varicose Veins.—MR. W. THORNLEY STOKER, of Dublin, presents the following as a new method of operating for the cure of superficial varicose veins. He advocates the total abolition of the ligature, on the grounds that it is an added danger, and is in any case useless. He has lost two patients from septicemia, after apparently trivial operations of election for the cure of varicose veins in the lower extremity, and where every antiseptic precaution had been observed. In these cases ligatures had been used. In his method without ligatures the steps are as follows: The patient is kept in bed for two or three days to allow the veins to contract; the bowels are well cleaned out, and the skin of the parts to be operated on is rendered aseptic by: (1) Scrubbing with soap and water. (2) Washing with ether. (3) Keeping for 24 hours in a dressing of 1:40 solution of carbolic acid, covered with mackintosh, and changed two or three times. No anesthetic is employed unless the patient insists on it. The pain is insignificant, and the probable struggling under ether or chloroform interferes with the niceties of the method. If anesthesia is desired, it should be general rather than local. No Esmarch bandage should be applied, as it empties the veins and renders them difficult to find. The skin incision causes no hemorrhage that pressure of a sponge does not stop. The position of the veins should not be indicated by pencil or dermatograph, as it may render the wound septic. If necessary the patient may be made to stand up so as to congest the veins. At each place where it may be thought necessary to divide the veins an incision about half an inch long should be made in the vertical axis of the limb, the superficial fascia divided with an oculist's scissors, the vessel lifted from its bed, a quarter of an inch cut from its length, and gentle pressure applied with a sponge. When this procedure has been repeated at all necessary points the part should be irrigated with sublimate solution, flat compresses of sterilized gauze applied to each incision, a dressing placed over them, and the limb bandaged from the toes to above the seat of operation. The patient should be kept in bed and not allowed to rise from the horizontal position for a week. The essence of this method is that, while a ligature is not employed, the wound is treated as an open one, and no sutures introduced into the skin. The advantage of these is that the danger of infecting the vein is lessened, the possibility of a clot of blood forming subcutaneously, with its attending risks and inconveniences, is avoided, and a rapid as well as a safe recovery is provided for. It should be remembered that owing to the low tension of the blood in the veins, very slight pressure is required to control hemorrhage from them, and, therefore, thick compresses and tight bandages subsequent to operation are to be avoided; they are not required, and only serve to impede capillary circulation and delay repair.—*Dublin Journal of Medical Science*, March, 1895.

A Modification of the "Invagination" Method of Operating for the Radical Cure of Hernia.—DR. JOHN H. PACKARD writes as follows: The method which I wish to describe consists essentially in the invagination of the isolated sac. I explore the hernia by a curved incision, describing a semi-circular flap of ample size. This carries the cicatrix away from the seat of the trouble. The sac being laid bare is isolated from the external ring down to its tip. Sometimes it is better to empty it during this process, which may often be accomplished by tearing with the fingers. In order to secure control of the empty sac, I now pass a silk thread through its wall at either side; the two ends of each are left long, and caught in hemostatic forceps. With the forefinger of the left hand the tip of the sac is now inverted and pushed up as far as the internal ring, or as near it as possible. Next a slightly curved needle with an eye near the point, and armed with a thoroughly sterilized silk thread is passed up along the finger as a guide, to be pushed out at one side of the tip through the tendon of the external oblique muscle. One end of the thread being caught the needle is withdrawn slightly, and again pushed through the tendon at the other side of the tip. The other end of the silk thread is now detached from the needle, which is wholly withdrawn, and the two ends, left slack, are caught together in a hemostatic forceps. Now, by means of the two latest threads, and by grasping in the fingers, the double sac is drawn down carefully, and with a small curved needle a fine silk suture is passed through it from side to side, from below upward, as far as possible, and then from above downward, so that its two ends, when drawn tight, will crumple up the sac into a solid mass. These ends are tied and cut off short. The lateral threads are now removed, and the other silk thread is drawn up tight, pulling the plug formed of the sac into place at the internal ring; its two ends are tied on the outer surface of the tendon of the external oblique, and cut off short. The skin flap is laid over in place again, the wound closed by sutures, and the ordinary antiseptic dressings applied. Until the wound is completely healed the patient is kept in bed. I have not put a truss on any of the patients recently subjected to this operation, but have cautioned against making any muscular effort likely to bring undue stress upon the parts until time enough has elapsed for their consolidation.—*Times and Register*, April 6, 1895.

Immobilization vs. Passive Motion in the Treatment of Injuries of the

Joint.—DR. R. HARVEY REED, in a paper upon this subject before the Association of Erie Railway Surgeons, says: In traumatisms affecting the joints, the question that confronts the surgeon is, how to treat them so as to give the best results. Whilst our text-books differ as to just when passive motion should be inaugurated, and how extensively it should be used, yet I have been unable to find a text-book which does not advise its use in some form. The results of following these instructions have not been satisfactory, and consequently surgeons are on the alert for practical methods that will give better results. Those who favor passive motion fear fibrous or bony anchylosis occurring during immobilization. One author says: Passive motion is perfectly safe, and if carried out under proper supervision may be commenced in the first week. It stretches out the folds of the capsule and prevents the muscles and ligaments becoming shortened, and checks the formation of the adhesions without endangering the prospects of union, or giving the faintest reason for inflammation. Let us consider the condition of things in a fracture at the elbow. There are ruptures of ligaments and capsule, injuries to blood-vessels, nerves, and surrounding soft parts. There is extravasation, impairment of circulation, and frequently plastic exudation. These conditions being present, it is the primary duty of the surgeon to replace the parts as nearly as possible in their normal position. Next the reparative process should be encouraged, which absorbs blood clots, infiltrates and exudates and unites the ruptured parts. The restoration of injured vessels and the formation of new vessels are the most important steps in the process, for not only is nutrition brought to the injured parts by the blood-vessels, but the effete materials are by them carried away. Passive motion not only tears open the injured vessels and increases extravasation, but interferes with the building up of new blood-vessels. We are justified, then, in keeping the parts immobilized during the early or first stage of an injury. Having secured the absorption of the blood clots and effusion, and the repair of the blood-vessels, the true reparative process begins. Here, also, passive motion may act unfavorably by setting up an irritation, which may increase the blood supply beyond what is necessary and produce an exostosis, or an abnormal increase in the connective tissue, producing deformity and impairment of motion. In the third stage the provisional callus is absorbed, exostoses reduced and thickened connective tissue diminished. My experience recently, has led me to believe that "physiological rest" in the first two stages of the reparative processes of the joint gives better results than can possibly be obtained by passive motion. In the third stage, I am quite satisfied that we will receive better results from massage than we will from passive motion, although I admit that if passive motion is of any service, it is only in the third stage.—*Columbus Medical Journal*, February 19, 1895.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

Skin Grafting on the Eye-ball for Symblepharon.—DR. T. R. CHAMBERS reports a case of extensive symblepharon resulting from a burn by lime. In spite of the greatest care extensive bands of adhesion formed between the lids and the eye-ball. An elongated ellipsoid piece of skin was grafted from the adjacent temple upon the ball of the eye. The ball was first denuded of all cicatricial tissue, and the flap of skin was twisted around its pedicle at the external canthus and sewed to the ball, it being carried well down into the sulcus between the ball. The pedicle was severed on the fourth day. The appearance of the eye was greatly improved; it was relieved of severe pain; the vision was improved from perception of light to one-fifth normal.—*Medical Record*, April 20, 1895.

A Form of Iritis not Usually Recognized.—MR. BRAILY says he has collected a series of cases of iritis from which he formulates the following conclusions: (1) That a late form of iritis sometimes follows acquired syphilis, the average time for the attack not varying much from 13 years after the primary sore. (2) That such iritis is generally double, and its usual form is iritis serosa, or an irido-cyclitis, with comparatively little tendency to the formation of posterior synechia, and accompanied by dots on the posterior corneal surface; and also by the tendency to secondary glaucoma. (3) The patient may show other late manifestations of syphilis, as, for instance, ozena, choroiditis, disseminata, etc. (4) That a similar iritis may follow an inherited syphilis, the average age of the subject, though varying in wide limits, being approximate to 21 years. (5) That in inherited as in acquired syphilis the usual form is a double serous iritis; the iritis may, however, be of a much severer type with varying tension and occlusion of the pupillary edge. (6) That such an iritis may also be accompanied by larger and more cloudy dots on the posterior surface of, or perhaps deep in the cornea, such deposits with the other, resulting in the formation of a dense, non-vascularizing, triangular plaque, deep in or behind the lower part of the cornea. (7) That the iritis may more rarely be a different type, the gummatous, possibly with peripheral anterior synechia, or the adhesions leading even to exclusion of the pupil and consequent secondary glaucoma. (8) That, apart from the iritis, which simply attends and is quite secondary in degree to severe interstitial keratitis, the late serous iritis of inherited syphilis may show a close relation to interstitial keratitis. Thus a slight interstitial keratitis may be followed after an interval of months by a gummatous iritis, while the iritis with blocked pupil, deep triangular corneal plaque and varying tension is often accompanied by fine filmy or denser and more extensive opacities in other parts of the cornea. Characteristic syphilitic teeth are rare, or perhaps uniformly absent in the pure iritis serosa of inherited syphilis, while they are present in increasing frequency as the disease approximates in its associated character to interstitial keratitis. It is very noticeable that the subjects of the late serous iritis of inherited syphilis are often well developed physically.—*Medical Press and Circular*, March 27, 1895.

Ocular Complications in Diabetes.—DR. KOENIG says that diabetes provokes many disorders of the organ of vision. The most common of these disturbances are: weakening of the accommodation, occasionally causing paralysis of the muscles of accommodation, opacification of the lens. Among 500 diabetic patients whom the author had examined, at Vichy, he had found 56 cases—11 per cent—with ocular lesions. Among these, there were 10 cataracts, 20 cases of lesions of the accommodation, 2 cases of gangrene of the lids, 2 cases of hemorrhagic glaucoma, and 2 polioencephalitis. Diabetic cataracts are generally soft, and of a milky appearance; but, in very old people, they may resemble the ordinary senile cataract. Frequent complications of extraction of the senile cataract are edema of the lids and periorbital neuralgia. Generally, the operation is safe, and the incision heals as promptly as in the ordinary cataract operation. Glycosuric retinitis is characterized by minute retinal hemorrhages and small white exudates. The predominence of the latter and their grouping in the region of the macula indicate the presence of albumin in the urine. If the optic nerve is implicated, it will be changed in color or become white, as in simple atrophy. The 2 cases of atrophy of optic nerve presented points of interest. One, æt. 54, became blind from optic nerve atrophy after a fever; the other, æt. 6, had 57 gr. and 72 centigr. of sugar per liter. The classical form of visual defect in these cases is the loss of central vision, as indicated by round central scotoma. It is not infrequent that the discovery of the ocular complication is the first symptom to call attention to the constitutional condition.—*Progres Médical*, June 15, 1895.

Deaf Mutes—Can They be Made to Hear?—DR. L. J. LAUTENBACH arrives at the following conclusions in regard to the care of the ears of deaf mutes: (1) That no negative opinion as to the results of treatment can be considered as justified, even when all our ear tests fail to indicate the slightest trace of hearing power. (2) That every deaf mute should have his ears thoroughly examined, the proper treatment instituted, and that this treatment should consist not only of former methods, but should include pneumo-phono and mixed massage treatment. (3) That, as a result of this method of treatment, favorable effects have been obtained which have not been realized by any former treatment. (4) That, in the present status of our knowledge, we know not to what extent the power of hearing may be developed by this method; the lack being occasioned by a greater period of time to allow of further development of the hearing function. (5) That, even though the deaf mutes be not restored to normal or any where near thereto, yet the hearing power developed during the comparatively short period that this method has been in use, would prove of great value to the deaf mute, not only in the development of his speech functions and in the protection of his person from external injury, but would be of great value to his family and friends in their more ready communication with him. (6) That, through the improvement by the massage treatment, the teaching of deaf mutes of the lip reading method and the utterance of sounds in accordance with this teaching can be more readily accomplished and more deaf mutes thus be given the advantage of such education.—*Journal American Medical Association*, June 22, 1895.

Micro-organisms in the Healthy Nose.—DRS. THOMSON and HEWLETT made bacteriological examinations of the upper air passages, and as a result of their researches arrived at the following conclusions: (1) In all bacterioscopic investigations of the nasal fossæ, in all researches as to the action of nasal mucus, etc., a clear distinction must be made between the vestibule of the nose and the proper mucous cavity. The former is lined with skin, and is furnished with hairs and with sudoriparous and sebaceous glands; it is not part of the nose cavity proper, but only leads up to it. (2) The neglect of this distinction may account for the discrepancy in previous observations on the subject. Contamination with the lining of the vestibule is difficult to avoid, even when the source of error has been realized. (3) In the dusts and crusts of mucus and debris deposited among the vibrissæ of healthy subjects microörganisms are never absent. They are rarely scanty in number; as a rule they are abundant. (4) On the Schneiderian membrane the reverse is the case. The authors do not assert that microörganisms are completely absent; obviously some must occasionally occur, but, under normal conditions, they are never plentiful; they are rarely even numerous, and in more than 80 per cent. of the observations no organisms whatever were found, and the mucus was completely sterile. (5) The occurrence of pathogenic organisms must be so infrequent that their presence on the Schneiderian membrane can only be regarded as quite exceptional. Clinical experience bore out the above conclusions, and their application in practice was sufficiently obvious.—*British Medical Journal*, June 1, 1895.

Massage of the Eye.—M. PARANTEAU recommends active massage for certain diseased conditions of the lids, such as cystic growths, chalazions, engorgements, etc. In diseases of the eye itself he considers violent massage dangerous. Massage with medicine has a double usefulness in bringing the ointment or powder into more intimate relationship with the diseased tissue and in rapid reduction of the ocular congestion. It is indicated in phlyctenular kerato-conjunctivitis, leucoma of the cornea, iritis, episcleritis, and irido-choroiditis. Massage is always indicated in muscular defects of peripheral origin, or from disordered vascular conditions. Massage is contraindicated in progressive myopia, increased intraocular tension, and in beginning opacities of the lens. In corneal or iris diseases the massage should be made in a radiating or circular direction, longitudinally in muscular lesions, and eddying or circular direction in episcleritis and irido-choroiditis.—*Révue Médicale*, June 16, 1895.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR.. M.D., Sacramento, Cal.

Treatment of Syphilis by Mercurial Injections in the Veins.—KUSEL has practised on four syphilitics in the clinic of I. Pospelow, of Moscow, intravenous injections of sublimate, after Bacceli's method, and has convinced himself of the inoccuity and efficacy of this mode of treatment. The hypodermic syringe used was provided with a needle bent at an obtuse angle, permitting it to enter easily into the canal of the vein. The injections were made, with the necessary antiseptic precautions, in a vein in the bend of the elbow, made prominent by the compression of the member above the vessel. Küsel advises plunging the needle rapidly in an oblique direction into the vein, crossing the skin, the subcutaneous cellular tissue and the coat of the vein at one thrust; for, if one proceeds slowly, the vein often escapes the needle. In this last case the injection is thrown into the surrounding tissues, and can be first recognized by the pains which it causes; then by the production at the surface of the puncture of a swelling, due to the accumulation of the injected fluid. When the intravenous injections of sublimate are properly made they never cause pain or alarming symptoms. In the case of one invalid, they have been followed by a stomatitis, necessitating stopping the treatment. Notwithstanding the very weak solutions of sublimate (1 to 3 per cent.) used, and of which never more than 1 c.c. was injected at a time, the actions of the injections on the syphilitic wounds was manifest in all the cases.—*Journal de Médecine de Paris*, June 2, 1895.

Treatment of Tertiary Syphilitic Accidents of the Eye.—An experience of more than fifteen years has convinced M. GALEZOWSKI that iodides have no effect whatever on syphilitic choroiditis. Having employed, without success, during two or three years, iodide of potassium, in strong doses, he has had to return to mercurial frictions of the joints, after his own method, with a dose of 2 gms. a day during two consecutive years. In certain cases, he uses iodide of potassium, and recognizes an important curative action. This action, however, is nothing but an elimination of the mercury when the mercurial intoxication proceeds too far and continues the treatment. If the symptoms of poisoning become increased by the effect of the iodide, he recommends the frictions, which should be continued during two consecutive years. He concludes: One must not be contented with merely treating the symptoms of tertiary syphilis, such as mydriasis, ptosis, diplopia, paralysis of accommodation, etc., but it is indispensable to state the principle that from the beginning of tertiary accidents of the eye, one must commence treatment for two years with mercurial frictions. It is in this way, and only in this way, that we can succeed, in time, in dealing with the ataxic accidents of the eye and of the optic nerve.—*Journal de Médecine de Paris*, June 16, 1895.

Syphilitic Neuritis.—TAYLOR has observed two cases of this disease. In one, there was anesthesia and progressive analgesia of the extremities, of pain in the legs, no paresis; in the other case, ulcerations, which necessitated amputation. In the second case the trouble was localized in the sciatic nerve, and consisted of gummy infiltration. Fordyce has also observed syphilitic neuritis twice; once it reached the facial nerve; in the other case, it manifested itself by paralysis of the legs. The interstitial nature of certain syphilitic neurites can sometimes be determined by exploration of the accessible nerves, which will be found enlarged.—*Gazette des Hôpitaux*, June 1895.

Venereal Diseases in the French, Russian, and English Armies.—The highest number of cases of venereal disease in the French army was recorded n 1875—74.9 per 1,000 men. During the same year the proportion in the English army was 139.4 per 1,000. The highest number in the English army was in 1885—274.4 per 1,000. In the French army during the same year the proportion was only 52.1 per 1,000. If these statistics are examined regarding syphilis the following results are found: In the French army the highest proportion of men attacked by syphilis was in 1875—11.3 per 1,000. During this year the number of soldiers affected in the English army was 28.8 per 1,000 men. The highest number of English soldiers with this disease was in 1887—46.6 per 1,000. The proportion of French soldiers attacked during this year was only 8.9 per 1,000, or five times less. No matter what year we compare either the syphilitic cases or venereal diseases we find the same difference. From the statement of the sanitary condition of the Russian army during 1889, '90, '91, and '92 we find that for all the venereal diseases there is little difference between Russia and France. The proportion of syphilitics is higher in Russia than in France, but it is much below that of the English army. The cases in the latter being four times more numerous than in either of the former. A comparison of the number of soldiers treated in France for syphilis shows that it is a quarter of that of the English soldiers admitted into hospitals for the same affection, and the number of syphilitics in Russia is almost a third of those found in the English army. DR. COMMENGE in pushing his investigation further, and in studying specially the environment of the French army, shows that the different regiments have more or less soldiers attacked with venereal diseases according to whether they are in garrisons in the localities where clandestine prostitution is more or less developed. It was particularly noticed that the same regiments have always the greatest number of venereal diseases. The regiments of the Midi and of Algeria, the military police of Paris, and the Third Regiment are named as having the most tainted soldiers. The totality of disease for the whole army, in 1890, was 43.8 per 1,000. In these figures the Third Regiment is represented by 84 per 1,000, while the Eleventh Regiment gives only 26.3 per 1,000. This inequality in the division of venereal diseases is noticed also in the same regiment according to the garrison it occupies. In the Third Regiment, in 1892, the garrisons of Elbeuf and Vernon were affected in the proportion of 6.84 and 6.75 per 1,000, while in the garrisons at Havre and Rouen the number of venereal soldiers is 97.27 and 98.32 per 1,000: It must, therefore, be that the ascending progression of venereal diseases is in comparison with the laxity of morals and the development of clandestine prostitution.—*Révue Médicale*, June 2, 1895.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

The Antipyretic Action of Alcohol.—BLAISE calls attention to the antipyretic action of alcohol following its absorption through the skin. It appears from the experiments of Linossier and Lanois, made with crystalized synthetic guaiacol (*alpha*), that this action is due to the absorption by the skin of the vapors of this medicament. The guaiacol (not more than 30 grains) is liquefied by gentle heat in a test tube, and painted with a small brush over the breast of the patient. The area painted is then immediately covered by adhesive gummed or rubber plaster. In 15 minutes the taste of guaiacol will be perceived by the patient, and the temperature quickly falls from one to three degrees, slowly ascending again to its initial point in the course of three hours. The cases in which it is particularly indicated are those of pulmonary tuberculosis with febrile attacks; it can also be used in typhoid fever, erysipelas, etc. In pleurisy 45 grains of guaiacol dissolved in 6 drachms of tincture of iodine may be applied in the same way; two applications in 24 hours.—*British Medical Journal*, May 12, 1895.

Action of Antipyrin on the Central Nervous System.—LANGLOIS and GUIBAUD by graduating doses on animals whose spinal cord had been divided below the medulla oblongata, could distinguish several stages of poisoning: (1) A cerebral stage in which clonic epileptiform convulsions are limited to the head. (2) A cerebro-spinal stage in which the head is still affected with clonic convulsions, while the trunk is attacked with one or more tonic spasms (opisthotonos). (3) A cerebral stage with spinal hyper-irritability, in which the shocks caused by the clonic convulsions of the head set up violent reflex movements of the body, comparable to the spasms of strychnine poisoning. (4) The reflexes of the head disappear at the same time as those of the trunk. Antipyrin has, then, an eclectic action in the higher centers, and this explains why its sedative action is more marked in head affections than in spinal.—*British Medical Journal*, May 4, 1895.

External Application of Pilocarpin in Nephritis.—MOLLIÈRE advocates the treatment of the various forms of Bright's disease by the inunction into the skin of the trunk of a dilute ointment of nitrate of pilocarpin. By this method can be obtained a purely local diaphoresis with a minimum dose of the alkaloid, and without the inconveniences and dangers which sometimes attend its subcutaneous injection. The *modus operandi* in cases of Bright's disease is as follows: An ointment is made of nitrate of pilocarpin with white vaseline, 1:1000 or 2000. About three ounces of this is rubbed into the skin over the whole of the trunk, which is then enveloped in a thick layer of cotton wool and waxed linen, the whole maintained in place by bandages. This "carapace" may be left on for several hours, or even until the reapplication of the dressing on the following day. In ordinary cases this treatment may be repeated daily for 10 or 15 days. Mollière finds the results exceedingly satisfactory, even when, as in his later cases, the usual restrictions of diet and other routine treatment have not been combined with the inunction. In acute cases threatened uremia is averted and the dyspnea is relieved; there is profuse diaphoresis and salivation, increase in the amount of urine, diminution of albumin, and a rapid disappearance of anasarca. The cure is rapid and complete. In chronic cases he claims that it produces greater alleviation of symptoms and prolongation of life than any other remedy.—*British Medical Journal*, May 25, 1895.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Myasthenia Gravis Pseudoparalytica.—JOLLY presents the following anamnesis in brief of a boy, 14 years old, suffering from this rare affection. The first symptom noted was a tendency of the eyelids to close, when any continued effort of vision was made. Then followed weakness of the legs, the boy suddenly falling on the street at times from sheer weakness. The muscles of the arms were next involved, and, still later, the muscles of the neck, lips and of mastication. While eating he would often stop to enable him to rest the muscles of mastication. The characteristic features of the affection noted were absence of atrophy, and hypertrophy of the affected muscles, involvement of all the voluntary muscles to a varying extent, and restoration of muscular power after rest. Up to the date of the report 17 cases of pseudoparalytica myasthenia have been reported, of which 11 cases terminated fatally. The first characteristic description of the disease was by Erb, in 1878, at which time he reported 3 cases under the title, "On a New, Probably, Bulbar Symptom Complex." In one of the cases death occurred suddenly. In all 3 cases the manifestations of muscular weakness were most pronounced in the neck, throat and masticatory muscles, whereas the muscles of the extremities were only partially implicated. As no anatomical evidence of disease can be found in the medulla oblongata, the name bulbar paralysis, without anatomical evidence, has been suggested. Strümpell has recently suggested the name, "Asthenic bulbar paralysis." Theories to explain this affection are plentiful, but they rest on no substantial foundation. The treatment recommended by Jolly is largely symptomatic.—*Berliner klin. Wochenschrift*.

The Diaphragmatic Phenomenon and Its Clinical Importance.—The "Diaphragmatic Phenomenon" consists, according to LITTEN (*Wiener klin. Woch.*), of recognizing the movements of the diaphragm on either side of the chest, beginning at the 6th intercostal space, descending a number of intercostal spaces during deep inspiration to rise again during expiration. In superficial breathing the play of the diaphragm does not extend beyond 1 to 1½ intercostal spaces; in deep inspiration from 2 to 3 and over. The phenomenon is some times manifest over the entire thorax. It is best observed by tangential illumination of a part of the thorax. The patient is placed in a horizontal position, the feet toward the window, the observer with his back toward the window, looking at the thorax at an angle of 45°. The diagnostic value can be appreciated in many conditions. In emphysema the movements begin lower down, and the extent of excursion is limited. In cases of fluid in the pleural cavity, or pneumonia, the movements on the affected side are diminished or absent. This also applies to pleural adhesions. If dulness of the lower half of the thorax is present, and, notwithstanding this fact, movements can still be noted above the line of dulness, the evidence is in favor of a subphrenic abscess. In tumors of the thorax the movements are abnormally low, whereas in liver tumors they are very high. In high-grade ascites, peritonitis and diffused liver tumors, the phenomenon is usually absent.—*Therapeut. Monatshefte*, May, 1895.

Copper Intoxication.—DR. OPPENHEIMER describes a case of a coppersmith who had been working in copper work for four years, exposed to very fine copper dust. He was not very cleanly in his habits. For six months he had had vague stomach symptoms, nausea, occasional vomiting, some distress, but no actual pain after eating; no colic. Examination of chest and abdomen was negative. The chief point of interest was the hair; it was a pale, but quite distinct green. This was more marked in the hair on the head and of the mustache; but all over the body, in the axillæ, over the pubes and shins, there was the same coloration. Copper was easily demonstrated, chemically. Boiling of the hair in water did not remove the color, but ammonia did so at once. Greenish hair, with men in copper works and in copper mines, is not unknown. The men, as a rule, avoid coloration by scrupulous cleanliness. The part first affected is the mustache, and next the head; though if the latter is protected by a thick cap, it will be free. The color appears a few days after starting work, and is more apt to come during summer time, when they sweat freely. Then the underwear has a greenish tinge wherever it has been thoroughly wet with sweat. They seldom have any gastro-intestinal disturbance, but a severe distressing cough is not uncommon, and occasionally ends fatally.—*Johns Hopkins Hospital Bulletin*, March, 1895.

Casts in the Urine Without Albuminuria (Serum Albumin.)—KOSSLER reports a number of cases showing renal casts in the urine without true albuminuria. By the help of the centrifugal apparatus, this fact was repeatedly demonstrated. Examination in this direction was positive in 18 cases of chronic pulmonary tuberculosis, 2 cases of rheumatic endocarditis, 3 cases of infectious pulmonary disease, 1 case of typhoid fever and 2 cases of phosphorus poisoning. In no case was there any clinical evidence of amylordosis, nephritis or circulatory disturbances. The character of the casts were hyaline, granular, waxy, leucocytetic cylinders, epithelial and blood cylinders. In the majority of cases, along with cylindruria, nucleo-albuminuria was present. The epithelial cells from the kidney were in all stages of necrobiosis, as demonstrated after death. Kossler, as a result of these investigations, refers to cylindruria and nucleo-albuminuria as a syndrome *sui generis* to be differentrated from cylindruria with true albuminuria.—*Wiener med. Presse*, February 3, 1895. [Nucleo-albumin was formerly known as true mucin. In making the reaction for this substance, we deal only with nucleo-albumin held in solution. It is recognized by adding to the urine, acetic acid in excess. Should the urine become cloudy, the presence of nucleo-albumin is established, especially if the urine has been previously diluted. The cold uterine acid test for albumin is positive with this substance, and this fact no doubt accounts for the false opinion that serum albumin is a constant physiological ingredient of the urine. A. A.]

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

A Case of Dual Brain Action.—A peculiar case of this nature was recently reported by DR. LEWIS T. BRUCE. The patient, a Welshman, aged 47, appears to have two separate and distinct states of consciousness, as if the right and left brain alternately exerted a preponderating influence over the motor functions. The two states of consciousness are called by the author the English and the Welsh stage, because he spoke in each stage the language which is indicated by the name. When in the English stage he is right-handed, and is presumably using the left cerebral hemisphere. He then writes, talks and understands English, and appears to be suffering from a chronic mania. He is restless and mischievous, but bold, fearless and fairly intelligent. He writes fairly legible with the right hand, and will, if asked, produce mirror writing (from right to left, making his letters backward) with his left hand. He does not remember anything that occurred when he was in the Welsh stage. His special senses are unimpaired. He presents no symptoms of physical disease. In the Welsh stage he is left-handed, probably using the right cerebral hemisphere. He speaks and understands Welsh, but has no knowledge of English. The mental symptoms present in this stage are those of dementia, the reverse of those in the English stage. He is shy and suspicious. He writes with the left hand, and makes the capital letters backward. The special senses seem intact, but he is unable to analyze and appreciate crude sensations. He does not seem to know coins or tobacco, of which he is very fond in the English stage. He cannot sort out the primary colors, is alarmed at the tuning-fork, and does not prefer sugar to salt. His circulation is weak, and he seems very dull. The author is of the opinion that the direct cause of the transition from one stage to another is some circulatory change. Sphygmographic tracings of the radial pulse show a pulse of high tension when in the English stage, and lower tension and less volume in the Welsh stage. The change from one stage to another may occur suddenly after a meal or a bath, or during sleep, or there may be an intermediate stage, during which he is ambidextrous, and employs both English and Welsh words. The observations of this case would seem to show that each cerebral hemisphere is capable of individual action, and that he lives two separate existences, the mental impressions of each existence being recorded in one cerebral hemisphere only. Judging by the characteristic symptoms in this case it would seem that disease has advanced more rapidly in the right hemisphere than in the left.—*Brain*—*International Medical Magazine*, April, 1895.

Comparative Responsibility of the Consulting and Attending Physician.—MR. LORENZO D. BULETTE, of Philadelphia, in speaking of the degree of responsibility of the consulting and attending physician, says that this necessarily depends upon the relation in which the consultant places himself towards the patient. He first quotes from Ordronaux' Jurisprudence of Medicine, p. 101. This author says that "if he be called in but once, and for the purpose of counselling alone, it is clear that his contract and responsibility both terminate with his visit. * * * But if the consulting surgeon be called in for the purpose of performing an operation, and does perform it, he gives a new direction to the case and becomes responsible for the immediate effects of such operation. When, however, he has handed over the case, at a safe stage of its treatment, to the attending surgeon, his responsibility clearly ceases. If, on the other hand being originally called in to counsel, the consultant consents to undertake the treatment of the case in connection with the attending surgeon, he thereby constitutes himself a principal in the transaction, while the latter acts as his agent, and upon the general principles regulating this relation he becomes responsible for that agent's treatment wherever those results flow directly from the legitimate exercise of his duties." Bulette says that the number of actions against surgeons alone is far in excess of the number brought against physicians for malpractice, for the reason that the results of the surgeon's work are patent—the scars and deformities are remembered, while the good intention, the care and skill exercised in the performance of a difficult operation are ungratefully forgotten. It is generally held that where a surgeon and physician act on an equality in the treatment of a case they are jointly liable. Mr. Bulette gives the case of Slater vs. Baker & Hamilton (2 Wilson's Rep., 359—1767), as an example of what will constitute a joint liability between a consulting and an attending physician. The plaintiff had broken both bones of one leg, but the fracture had been set, the callus had formed, and he was able to walk with crutches. At this juncture Slater, who was an apothecary, was sent for to remove the bandages, but, declining to act alone, he requested that Dr. Baker be called in to assist him. Dr. Baker was an eminent surgeon, and a lecturer on surgery and anatomy in St. Bartholomew's Hospital in London. It also appeared in evidence that the third time the defendants called to see plaintiff Dr. Baker took up the plaintiff's foot in both hands and nodded to Slater, and then Slater took plaintiff's leg upon his knee, and the leg gave a crack, when the plaintiff cried out and said, "You have broke what nature had formed." Dr. Baker then said, "You must go through the operation of extension;" and Slater said, "We have consulted and done for the best." After trial and a verdict for the plaintiff for £500, it was, on motion in arrest of judgment, objected on behalf of the defendants that, inasmuch as both defendants were joined in the same action on the theory of a joint liability, it should be proved, but that there was no evidence of a joint undertaking. The court was, however, of the opinion that the facts as here stated constituted sufficient evidence of the joint liability of the defendants, and their motion was accordingly denied.—*International Medical Magazine*, April, 1895.

FORMULÆ.

To Prevent Cracked Nipples.—DR. VIRGINIA M. DAVIS is accustomed to apply lanolin with the onset of labor four times daily till lactation is established. The nipples are then, after each nursing, anointed with the following:

Tr. benzoin. comp.	gtt xv	
Ol. olivæ	ʒ ii	
Lanolin	ʒ vi	M.
et ft. ung.		

—*Prescription.*

Local Anesthesia.—THOMAS prescribes:

Cocainæ hydrochlor.	gr. xlviii
Liq. nitro-glycerini (1%)	ʒ iiss
Aq. dest.	℥ i

S.—For topical application to pharynx and larynx.—*College and Clinical Record.*

A Useful Expectorant in the Broncho-Pneumonia of Children:

Ammon. acetatis.	
Sod. benzoatis	āā ʒ iiss
Sp. vini gallici	ʒ ss
Syr. tolutani	℥ iss
Syr. acaciæ	℥ ii

S.—A teaspoonful every two hours, increasing or diminishing the dose according to age.—*Medical Press and Circular.*

Urticaria of Children:

Chloral hydr.	
Camphoræ pulv.	
Acaciæ pulv.	āā ʒ i

Triturate till liquefied, then add

Cerat. simpl.	ʒ i

S.—Apply topically.—*Canada Medical Record—Medical and Surgical Reporter.*

Pick's Gelatine Paint:

White gelatin	ʒ vi
Glycerin	ʒ ix
Dextrin	ʒ i
Oxide of zinc	ʒ vi
Water	℥ ii

S.—Dissolve the gelatin in water, applying heat; rub up the dextrin in the glycerin, and add to the gelatin when dissolved. When all is liquid add the oxide of zinc thoroughly powdered.—*International Medical Magazine.*

Eczema.—COTTELL advises:

Olei cadini	m xxx
Zinci oxidi	ʒ ss
Bismuthi subnit.	ʒ ss
Ungunti aq. rosæ	℥ i

—*American Practitioner and News.*

Application for Recent Ring Worm:

Thymol	ʒ ss
Chloroformi	ʒ ii
Ol. olivæ	*ad* ℥ i

S.—To be applied night and morning.—*Medical Press.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for June, 1895.—The deaths registered in 61 town districts of the State, during the month of June, in a population of 762,023, correspond to an annual rate of 14.28 a thousand, the total mortality having been 908. 72 deaths were due to zymotic diseases, giving an annual rate of 1.12 a thousand. Of these, 4 were due to diphtheria, 24 to cholera infantum, 18 to typhoid fever, 7 to diarrhea and dysentery, 5 to cerebro-spinal fever, 2 to whooping cough, 6 to croup, 2 to intermittent and remittent fevers, 3 to scarlet fever, 1 to measles, and 0 to small-pox. 255 deaths resulted from diseases of the respiratory organs, giving an annual rate of 3.96 a thousand. Of these, 187 were due to consumption, 43 to pneumonia, 24 to bronchitis, and 1 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.88 and .67, respectively. 71 deaths resulted from diseases of the heart, 2 from alcoholism, 4 from erysipelas, 26 from cancer, and 374 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 593,000, was 14.40. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from Sacramento, the lowest from Alameda.

METEOROLOGY.

Summary for June.—*Temperature.*—The normal temperature of the State for June is 70.8°; the average for June, 1895, was 70.0°, a departure from normal of - 0.8°. The highest monthly mean was 96.4°, at Salton; the lowest, 51.7°, at Bodie. The maximum temperature was 123°, at Volcano Springs, on the 23d. The minimum, 20°, at Bodie, on the 1st. The greatest monthly range was 70°, at Turlock; the least, 22°, at Coronado. The absolute monthly range for the State was 103°.

Rainfall.—The normal precipitation for the State for June is 0.31 inches; the average for June, 1895, was 0.01 inches, a departure from the normal of -0.30 of an inch. The greatest monthly precipitation was 0.29 inches, at Bodie. The least, nothing, at numerous places throughout the State.

Wind.—The prevailing direction of wind was from the W.

Unusual Features.—There was no unusual meteorological phenomenon to record for the month.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for June, 1895.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn ....Cal.	76.2	104	50.0	------	------	------	0	0.00	------	----	----	----	N.W.	Southern Pacific Company.
Berkeley .... “	59.3	90	45.0	72.0	52.0	20.0	0	0.00	81.0	21	5	4	S.W.	Obs. University of California.
Colfax .... “	73.7	104	48.0	------	------	------	0	0.00	------	----	----	----	N.E.	Southern Pacific Company.
Coronado .... “	64.0	75	53.0	69.0	59.0	10.0	0	0.00	78.0	21	6	3	W.	Hotel del Coronado.
Eureka .... “	53.0	70	42.0	58.0	47.0	11.0	----	0.06	86.0	11	18	1	N.W.	Weather Bureau Dept. Agr.
Fresno .... “	78.0	109	47.0	95.0	60.0	35.0	0	0.00	34.0	30	0	0	N.W.	“ “ “
Independence .. “	72.0	95	40.0	85.0	38.0	47.0	1	T	18.0	23	5	2	N.W.	“ “ “
Los Angeles .... “	66.0	100	47.0	77.0	54.0	23.0	1	0.01	73.0	9	21	0	W.	“ “ “
Monterey .... “	58.6	78	48.0	------	------	------	0	0.00	------	----	----	----	S.W.	Southern Pacific Company.
Napa .... “	67.5	94	48.0	80.0	54.0	26.0	0	0.00	66.0	26	4	0	S.W.	Station Napa Insane Asylum.
Oakland .... “	60.0	92	46.0	73.0	52.0	21.0	0	0.00	77.0	21	8	1	W.	Chabot Observatory.
Paso Robles .... “	66.0	102	36.0	85.0	47.0	38.0	0	0.00	42.0	30	0	0	W.	Southern Pacific Company.
Red Bluff .... “	78.0	108	51.0	92.0	65.0	27.0	0	0.00	30.0	27	3	0	N.	Weather Bureau Dept. Agr.
Sacramento. ... “	73.0	102	50.0	87.0	59.0	28.0	0	0.00	50.0	29	1	0	S.W.	“ “ “
San Bernardino “	70.0	99	42.0	89.0	52.0	37.0	0	0.00	50.0	29	1	0	S.W.	“ “ “
San Diego .... “	63.0	77	51.0	67.0	58.0	9.0	0	0.00	------	24	6	0	W.	A. K. Johnson, M. D
San Francisco .. “	59.0	86	48.0	66.0	52.0	14.0	0	0.00	78.0	21	6	3	W.	Weather Bureau Dept. Agr.
Santa Barbara .. “	62.0	90	46.0	71.0	54.0	17.0	0	0.00	82.0	20	7	3	S.W.	“ “ “
Santa Cruz ...... “	62.0	96	43.0	75.0	50.0	25.0	1	0.05	76.0	20	4	6	S.E.	Hugh D. Vail.
Yuma ....A. T.	85.0	109	53.0	102.0	67.0	35.0	1	T	36.0	28	2	0	S.W.	Weather Bureau Dept. Agr.

Blank (----) indicates data missing.

Occidental Medical Times.

Communications are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

Sacramento: August, 1895.

THE NEW FRENCH HOSPITAL.

The new Hospital of the French Mutual Benevolent Society was opened for the reception of patients on July 2d. The Hospital is situated on Point Lobos avenue, between Fifth and Sixth avenues, occupying a space of 240x600 feet. The pavilion plan has been adopted in its construction, the Administration building being located on the north, and the eastern and western aspects being reserved for the buildings occupied by patients. This gives a large central court, 140 x 190 feet, handsomely laid out with flowers and shrubbery. Under this plan space has been left for additional buildings of which one pavilion, for contagious diseases, is already under construction.

The two main pavilions begin at each angle of the Administration building. They are two stories in height, the first floor being reserved for paying patients, the second for the large wards, each of which contains twenty-two beds. Running along the inner sides of the pavilion is a long corridor, thus allowing a patient to be taken from any department into the operating room without being exposed at any point. The surgical pavilion, and one containing the operating room, is situated on the western side of the Hospital, and contains an elevator in which patients can be transferred, on a wheel stretcher, from the first to the second floor. The operating room has been constructed with regard for all the requirements of modern surgery. The inside walls are cemented, the lower five feet being covered with marble; the floor is tiled and there is a drain in the center. Light is admitted through a skylight and by three windows on three different sides. The usual gas and electric fixtures will be also employed. There are two distinct operating rooms, a room for the administration of anesthetics, one for the various apparatus, a consultation room and a recovery room. These rooms have been fitted up on the plan of the Pasteur and Lister rooms recently built in Paris, and contain improved sterilizing apparatus of every kind. The bath pavilion is, in itself, a hydropathic establishment. Medicated baths, Turkish baths, and ocean salt water baths can be given. A disinfecting oven, of sufficient size to admit all kinds of bedding, and in which disinfection by steam, under pressure, can be thoroughly carried out, is one of the features of the new hospital.

Special arrangements for heating the building have been adopted. In addition to the natural means, by door and window, a combined system of ventilating and heating by means of high speed fans, has been utilized. In each room and ward registers have been placed, enabling the temperature to be modified at any time by shutting off the heated air without interfering with the volume of air necessary for proper ventilation. Under this system the air can be changed every ten minutes in the operating rooms and every fifteen minutes in the wards, the temperature being maintained at 70° to 80° F. Drainage is good, ultimately connecting with the large sewer recently constructed to drain the Richmond district.

The following is the hospital staff: CHARLES B. BRIGHAM, H. DE MARVILLE, Surgeons; J. DE CHANTREAU, Physician; G. S. BOYD, Gynecologist; LEO NEWMARK, Neurologist; K. PISCHL, Oculist and Aurist; G. GROSS, Visiting Physician at homes of members; G. W. SICHEL, Dentist and F. H. VOISARD, Resident Physician.

THE SAN FRANCISCO BOARD OF HEALTH.

In the early part of July GOVERNOR BUDD announced his selection of the following gentlemen as members of the San Francisco Board of Health: J. F. MORSE, G. J. FITZGIBBON, H. H. HART, and J. M. WILLIAMSON. At the regular meeting of the Board held July 17th, the office was formally handed over to the new members, with expressions of good will and hopes that they would succeed in accomplishing many of the reforms attempted by the old Board. MAYOR SUTRO addressed them with congratulations on their appointment, and reminding them of the responsibilities attached to assuming charge of the municipal health.

At the first business meeting of the new Board held a week later, no time was lost in setting about the removal of the various officials in the health department. A. S. LOVELACE was appointed Health Officer in place of JAMES W. KEENEY. W. P. CHALMERS succeeded W. M. LAWLOR as Quarantine Officer. A. P. O'BRIEN succeeded S. S. KAHN as City Physician. CONRAD WEIL was appointed Police Surgeon in place of GEO. B. SOMERS. FRANK S. FITZGIBBON, EDWIN BUNNELL, and G. HOWARD THOMPSON were appointed Assistant Police Surgeons in place of G. HUNTINGTON REDDING, TENISON DEANE, and W. L. BERRY. Other changes were left to subsequent meetings. A. K. HAPPERSBERGER was made one of the inspectors of disinterments, and J. R. MCMURDO was appointed to investigate and sign Chinese death certificates. The appointments to positions open to the profession at the City and County Hospital have, up to this date, not been made.

The appointments thus far made are notable for their independence of political "pull." The chief offices have been filled entirely regardless of the recommendations of the politicians, or even of the Governor. It is not understood how strongly the Governor interposed in behalf of his political friends in the profession, but it is a fact that none of the best positions were allotted to the physicians who were most prominent in politics. From a professional standpoint the appointments are most satisfactory. Considerable care seems to have been taken to select men specially fitted for the respective places. The Receiving Hospital, for instance, which in former years received little or no attention, has been particularly well looked after, two of the staff of the German Hospital having been given positions here, with the obvious intention of transferring to the city institution the excellent regime of the former. The members of the Board have furthermore expressed their intention of supervising the public institutions in person, as far as possible.

NOTES.

An Outrageous Case.

The case which Dr. C. B. Nichols reported at length to the Sacramento Society for Medical Improvement, at a recent meeting, and which will be found on another page, is one of the most outrageous that it is possible to conceive. The perforation of the soft and friable wall of an infected uterus is perfectly possible and has occurred more than once in skilful hands. Similarly, a loop of intestine which has protruded through a ruptured uterus, when encountered in the vagina, may be at first mistaken for a prolapsed funis. A very cursory investigation, however, will reveal the true state of affairs. It is, therefore, as we have already said, inconceivable how any man in full possession of his faculties, and having the most elementary knowledge of anatomy and of practical obstetrics, could commit so fatal an error. To tear from its attachments almost fourteen feet of the small intestine, to completely denude it of its mesentery, and finally to sever its continuity by tearing it away from the cecum, implies an amount of physical force and brutal ignorance that compelled even the fully conscious patient, as well as her husband, who was present at the time, to recognize the true state of affairs. This certainly seems to be a case in which an investigation is demanded, and we believe that the Coroner who signed the death certificate, giving the cause of death as "abortion," seriously erred in the matter.

The Care of Persons Found Unconscious on the Streets.

The Medical Society of the County of Kings, Brooklyn, N. Y., has issued a circular on the care and disposition of persons found in an unconscious condition on the streets or elsewhere. The object of the communication is to draw attention to the necessity of providing, wherever possible, some systematic means of treating this class of patients. From time to time unfortunate cases occur where a person supposed to be drunk is cast into prison, and later the discovery is made, often too late, that something more serious than alcoholism is the matter. Such cases are not uncommon. The possibility of mistaking a dying man for a drunken man, even by experienced physicians, should be recognized by all municipal health and police departments, and measures taken accordingly. The recommendations of the Brooklyn Society are timely, and are in accordance with the position taken by THE MEDICAL TIMES for several years past. Many cases have been noted in these pages where serious injuries have been overlooked in persons apparently drunk. We have always insisted that unconscious persons taken in charge by police should be examined by the proper medical authority as soon as possible, and kept under observation until the diagnosis is assured. In San Francisco the necessity of providing for the unconscious is recognized, but the plans have not been perfected. Under the present condition of things the police surgeons stationed at the Receiving Hospital are subject to call for the examination of any cases that may seem suspicious to the Police Captain. There is a further understanding with the police department, that all cases found in an unconscious condition, whether due to alcohol or other causes, shall be taken at once to the Receiving Hospital. The majority of these cases are entered on the books as "Doubtful—held for observation." If the case proves to be simply alcoholism, the patient is either discharged or handed over to the police for prosecution. This system cannot be deemed complete until all discretion in these cases is removed from the police. This can be done only through a complete ambulance service, wherein surgeons may be readily called to decide upon them.

Advertisements of Secret Remedies

At several meetings of the American Medical Association, committees from the Medical Society of the State of Pennsylvania have been exceedingly active in urging that *The Journal* of the Association should refuse to publish advertisements of proprietary preparations unaccompanied by a formula. At the San Francisco meeting the Association declined to interfere with the Trustees of *The Journal*, but at Baltimore the Trustees appeared to have experienced a change of heart. According to a circular now being issued by the Medical Society of Pennsylvania, the following occurred in the report of the Trustees, as presented at Baltimore in May last: "During the year no advertisements of secret remedies have been accepted that were not accompanied by a formula, but to still further comply with what appears to be the desire of a large number of those interested in the highest success of *The Journal*, the editor, with the termination of the present contracts, has been instructed to accept no advertisements of medicinal preparations the proprietors of which do not give a formula containing the official or chemic name and quantity of each composing ingredient to be inserted as a part of the advertisement." This is certainly a victory for the Pennsylvanians, and they are now preparing to follow it up by endeavoring to procure similar action on the part of medical journal publishers throughout the United States. We believe it will be many years before the profession in this country will discard proprietary preparations, if they ever do so. Some have attained such a hold on practitioner and specialist, alike, that they will not be displaced with the present generation. It is, therefore, exceedingly desirable that the consummation sought by the Pennsylvania State Society should be brought about, as it is open to no possible or legitimate objection except from a purely commercial standpoint. There are a number of favorite and excellent proprietary preparations of which the formulæ have been given for many years, and it only remains for those that are equally popular to follow suit.

Committees of the State Medical Society.

The following are the Standing Committees of the Medical Society of the State of California, for 1895-'96:

Committee on Clinical Medicine, including Diagnostics and Therapeutics—W. W. Kerr, San Francisco, Chairman; J. S. Sargent, Santa Rosa; Washington Dodge, San Francisco; J. T. McDonald, San Francisco; R. H. Burke, San Jose.

Surgery and Clinical Surgery—C. L. Bard, Ventura, Chairman; T. W. Huntington, Sacramento; D. D. Crowley, Oakland; J. Rosenstirn, San Francisco; J. F. Morse, San Francisco.

Pathology and Pathological Anatomy—Emmet Rixford, San Francisco, Chairman; Geo. W. Lasher, Los Angeles; Albert Abrams, San Francisco, D. W. Montgomery, San Francisco; D. C. Barber, Los Angeles.

Diseases of the Mind and Nervous System—Leo Newmark, San Francisco, Chairman; H. E. Sanderson, Stockton; J. W. Robertson, Livermore; A. W. Hoisholt, Stockton; A. M. Gardner, Napa.

Medical and Surgical Diseases of Children—F. W. D'Evelyn, San Francisco, Chairman; H. M. Sherman, San Francisco, Jos. Kurtz, Los Angeles, E. A. Follansbee, Los Angeles; Chas. W. Nutting, Etna Mills.

State Medicine and Hygiene and Adulteration of Foods and Drugs—H. S Orme, Los Angeles, Chairman; J. R. Curnow, San Jose; G. F. Hanson, San Francisco; J. H. Bullard, Anaheim; A. W. Perry San Francisco.

Gynecology—Beverly MacMonagle, San Francisco, Chairman; Clinton Cushing, San Francisco; W. A. Edwards, San Diego; H. Kreutzmann, San Francisco; Charlotte B. Brown, San Francisco.

Obstetrics and Puerperal Diseases—C. A. Von Hoffman, San Francisco, Chairman; G. W. Davis, San Francisco; J. Q. Wrenn, Placerville; G. P. Reynolds, Alameda.

Histology and Microscopy—J. H. Stallard, San Francisco, Chairman, J. C. Spencer, San Francisco; Lulu T. Ellis, Los Angeles; C. G. Levison, San Francisco; Emma S. Merritt, San Francisco.

Indigenous Botany, Materia Medica, Pharmacy and Medical Chemistry—W. P. Gibbons, Alameda, Chairman; R. S. Markell, Cloverdale; J. T. Stewart, Los Angeles; T. M. Todd, Auburn; B. W. Day, San Diego.

Medical Topography, Meterology, Endemics and Epidemics—R. F. Rooney, Auburn, Chairman; H. D. Robertson, San Francisco; T. E. Taggart, Bakersfield, W. J. G. Dawson, St. Helena; K. D. Shugart, Riverside.

Necrology—L. E. Felton, Hanford, Chairman; H. N. Rucker, Oakland; G. I. Cason, Colusa; E. E. Stone, Marysville; F. D. Bullard, Los Angeles.

Prize Essay—J. H. Utley, Los Angeles, Chairman; D. W. Montgomery, San Francisco; Wm. Fitch Cheney, San Francisco.

Dermatology and Venereal Diseases—Geo. Chismore, San Francisco, Chairman; M. Regensburger, San Francisco; G. J. Bucknall, San Francisco; G. C. Simmons, Sacramento; F. Dudley Tait, San Francisco.

Ophthalmology and Otology—Kasper Pischl, San Francisco, Chairman; H. I• Jones, San Francisco; W. E. Briggs, Sacramento; R. L. Cox, San Francisco; A. F. Darling, Los Angeles.

Laryngology and Rhinology—W. E. Hopkins, San Francisco, Chairman; J. D. Arnold, San Francisco; M. H. Woolsey, San Francisco; M. C. O'Toole, San Francisco; H. L. Wagner, San Francisco.

Medical Jurisprudence—Chas. N. Ellinwood, San Francisco, Chairman; W. S. Thorne, San Francisco; R. L. Rigdon, San Francisco; C. G. Kuhlman, San Francisco; S. B. P. Knox, Santa Barbara.

Medical Education and Medical Legislation—R. H. Plummer, San Francisco, Chairman; H. H. Hart, San Francisco; A. H. Pratt, Oakland; J. R. Laine, Sacramento; Chester Rowell, Fresno.

Publication—A. P. Woodward, San Francisco, Chairman; S. R. Mather, San Francisco; W. W. Kerr, San Francisco; H. E. Sanderson, Stockton.

Executive Committee—W. R. Cluness, San Francisco, Chairman; G. L. Simmons, Sacramento; Henry Gibbons, Jr., San Francisco.

Committee of Arrangements—W. G. Cochran, Los Angeles, Chairman; J. H. Davisson, Los Angeles; W. D. Babcock, Los Angeles; Walter Lindley, Los Angeles; H. Nadeau, Los Angeles.

Special Committee on State Library—W. A. Briggs, G. L. Simmons, Jas. H. Parkinson, T. W. Huntington, Wm. Ellery Briggs, Sacramento.

Special Committee on Organization of Local and District Societies—G. L. Simmons, Sacramento.

Special Committee on Expert Witnesses—Geo. Franklin Shiels, San Francisco; Jas. H. Parkinson, Sacramento; F. W. D'Evelyn, San Francisco.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, June 25, 1895.

The President, C. B. NICHOLS, M.D., in the Chair.

New Sterilizer.—DR. W. A. BRIGGS exhibited a new sterilizer. The apparatus was made of copper and consisted of a case and three trays. The lower tray was for the reception of instruments, and was provided with an opening on the side to permit of the removal or the addition of an instrument without disturbing other materials. The instruments were sterilized with water, not with steam, which the speaker had found to be very destructive to them. Above the instrument tray was one for the dressings, and above that one which could be used for towels, operating coats, etc. The apparatus shown was quite large, and was intended to be placed on the ordinary kitchen stove. It would, however, be a very easy matter to heat it with two alcohol lamps.

Hernia—Fracture of Skull—Appendicitis—Gunshot Injury.—DR. W. J. HANNA said instead of a formal paper he desired to report some interesting cases that had occurred in his practice during the time he was in charge of the Southern Pacific Company's Hospital in the early part of the present year. He hoped the report would lead to a full discussion.

CASE I.—C. J. O'C——, laborer, age 20; presented himself at the Hospital February 12th, suffering from an inguinal hernia, left side. The trouble had existed about one year. Patient was prepared for operation, the skin being shaved and a pack of soft soap applied. After etherizing, the surface was washed with bichloride solution and then with ether. In cutting down, the sac was found and isolated, but upon opening it the omentum was found tightly adherent to the walls. In separating the omentum a rupture occurred which caused quite a severe hemorrhage, necessitating the enlargement of the wound in order to tie the bleeding vessels. The sac was tied off and the pillars of the ring closed by animal tendon, the external wound closed with silk worm gut, and a horse hair drain placed at the lower angle. Healing took place by first intention, and the case was practically well, all sutures being removed by the ninth day. Patient was advised to keep his bed for two weeks longer, and was discharged at the end of three weeks.

CASE II.—G. H. McL——, brakeman, age 36, was brought to the Hospital from Truckee, February 8th, in an unconscious condition and remained in a profound stupor for three days. He had been found on top of a box car upon the arrival of the train in Truckee. Examination showed a slight abrasion of the skin over the anterior and left side of the skull in the parietal region. Upon cutting off the hair with a clipping machine, no other evidence of injury could be detected. The temperature for the first three days remained at 102° F. The ice cap and collar were applied night and day until the temperature descended to 99° F. The patient regained partial consciousness and was able to make known his wants and recognize friends. His bowels were moved by means of saline cathartics, and he was regularly catheterized. At no time was there any evidence of paralysis. February 16th, seven days after admission, his temperature rapidly rose to 103°, 104°, finally reaching 105°. Assisted by Drs. Laine and Powell, the scalp being prepared by shaving, the skull was trephined on both sides in the parietal region. There was evidence of internal inflammation, but no clot or abscess. After the trephining, the temperature fell to 99°, but on the morning of the 17th, began to ascend, and the patient died February 18th, at 7:30 P. M. A *post-mortem* examination was performed on the same day and a long fracture was discovered, extending through the full length of the occipital bone to the foramen magnum. The blow was received upon the anterior and left side of the skull, the fracture occurring diagonally opposite, thus illustrating a case of fracture by *contre-coup*.

CASE III.—W. C. R——, clerk, age 33; February 15th the patient had been out to a coursing match and had become wet from exposure. That evening was taken with cramps, and I was notified of the fact, prescribing ¼ grain doses of morphine. The next morning saw the patient at his house and made the diagnosis of appendicitis. That evening saw the case again in consultation with Dr. W. A. Briggs, and later with Drs. Laine and Cartwright, all agreeing in the diagnosis. The patient was removed to the Hospital on the morning of the 17th. Assisted by Drs. Laine and Briggs an incision was made over McBurney's point. The abdominal walls were quite thick. The appendix was found bound down by adhesions, exploded, and the surrounding tissues highly inflamed. It was ligated and removed and the abdominal wound closed with silk worm gut. The patient did nicely after the operation, the temperature never going above 100° F., and there was no particular pain. At the end of the third day a saline cathartic was given after having administered six ½-grain tablets of the mild chloride of mercury. The temperature suddenly ascended to 103° F. Three of the sutures were removed and a probe inserted and about an ounce of pus evacuated. The cavity was irrigated with a mild bichloride solution syringed with a 2 per cent. solution of pyrozone and packed with iodoform gauze, the patient making a gradual recovery.

CASE IV.—J. McL——, machinist, age 25. Patient entered the Hospital complaining of great pain in the neighborhood of the appendix. He gave a history of the attack coming on three days previous while he was at work in Wadsworth, Nev. His temperature was 99°, and the pain disappeared after the administration of a saline cathartic. There was still some tenderness and induration at McBurney's point. The patient was prepared, and assisted by Drs. W. A. Briggs, Fowler, and H. L. Nichols, the abdomen was opened and about two ounces of pus evacuated. The appendix was found to be ruptured and a large fecal concretion had lodged in the opening. The appendix was tied off and removed, the wound washed with boiled water, and packed from the bottom with iodoform gauze. No complications were encountered during convalescence, the wound healing rapidly from the bottom.

CASE V.—C. W——, brakeman, age 24. Patient entered Hospital complain, ing of pain in the right groin. He gave a history of having had three previous attacks. Temperature, 100° F. A saline cathartic was given, but there still remained some tenderness and induration over McBurney's point. The case was seen by Dr. Gardner. The next morning, after being thoroughly prepared, the abdomen was opened and a highly inflamed appendix was found, tied off and removed, In separating the appendix from its attachments considerable hemorrhage was encountered. The abdominal cavity was freely irrigated with boiled water and the wound closed. In three weeks' time a good firm cicatrix had formed. The only complication in the case was that after putting the patient to bed his legs were quite severely burned by placing hot bottles next to the skin. This delayed his recovery for some weeks.

CASE VI.—On the evening of January 28th, I was called to the country to attend M. R——, who was said to be suffering from a gun-shot wound of the left arm. Examination showed the wound of entrance to be about four inches above the elbow joint on the inner aspect of the left arm, the skin being quite badly powder marked. The wound of exit was just below the external condyle there being a slight opening in the skin. Upon passing a probe into it, a hard substance could be felt. Assisted by Dr. Ogden, the patient was placed under chloroform, the arm thoroughly scrubbed with soap and warm water, an incision made and a 38 caliber bullet removed. The external condyle of the humerus was quite badly shattered, several fragments of bone being removed. The end of the radius could be felt plainly at its point of articulation with the humerus. The wound was thoroughly irrigated with bichloride solution, several fragments of cloth and other debris coming away. A rubber drainage tube was drawn through the arm, a dressing of iodoform gauze applied and the arm placed in a cardboard splint, in the flexed position. The case did nicely from the start. At the end of the third day a horse hair was substituted for the rubber tubing. At the end of the third week, chloroform was administered and passive motion made. This was repeated four times. The patient, at the present time, has nearly full use of the arm. After the accident there was a partial loss of sensation on the ulnar side of the thumb and the radial side of index finger. This has now partly returned.

DR. G. L. SIMMONS: This seems to me to be one of those injuries in which, in earlier times, a very unfavorable prognosis would have been rendered. Under the old method of treatment, I am sure there have often been more or less germs finding lodgment that have injured the parts, and the result would have been that the joint would have been so injured as to be stiffened and useless. This case now shows certainly a perfect arm, as far as I can see, in all its motions. I believe the young woman has also quite the power to touch the point of the shoulder with the fore finger. A compound fracture of the joint, would have met with a very unfavorable prognosis.

DR. T. W. HUNTINGTON: Regarding the first case, I have no criticism at all to offer. I am strongly of the opinion that where there is a fracture or depression of the skull, whether it be simple or compound, we should make a careful search as early as possible. One day early in January last, a young man had fallen quite a distance, producing a fracture of the cranium running along the frontal bone, taking the course of the saggital suture. My recollection is that the patient was not conscious at the time he came to the hospital. I operated on the line of the fracture, and was unable to pass the instrument underneath the fragment. There was an overreaching fragment and I could not succeed in getting a pry under it. On raising it, it would slip into place. A rush of blood, which was to me alarming, had come from the point where I had made an incision, and as to what course to pursue, I was not, for the moment, altogether certain. I trephined liberally; found that the longitudinal sinus had been opened and that the bleeding was coming from that point. I packed some gauze well down into the bottom of the cavity, completely arresting the hemorrhage. The case went on to rapid recovery. Patient was well in ten days or two weeks after the operation. In regard to the hernia case, there are some points not as clearly brought out as they should be. The one to which I allude particularly, is the case where the sigmoid flexure passes down into the hernial sac, that is, when hernia occurs on the left side. It is perplexing from the fact of there being no peritoneum on the sigmoid we have the bowel firmly attached to the sac. Coming to the matter of appendicitis, I shall allude to the frequency, in suppurative cases, of hernia which are found to occur in a very large number of cases operated upon under ordinary methods. While hernia is more apt to occur in suppurative cases, it also occurs in many cases, under all circumstances. The attention of the profession is now being called to this difficulty. I know of no way that this complication can be avoided in the first class of cases to which I alluded. I think McBurney has come nearer the many requirements of avoiding hernia than any other operator, by his method of separating the muscular fibers instead of dividing them this leaves a wound in which the superficial incision does not correspond with that in the deeper layers.

DR. W. A. BRIGGS: I had the privilege of assisting the author with all three of the cases. Both cases of appendicitis were certainly such as would have resulted fatally if not operated on in time. In the second case the symptoms to me were somewhat obscure; the point of tenderness and resistance were much nearer the median line and at same distance from the McBurney point. It is certain that operation is necessary in these cases, with severe inflammation, at an early period. As to hernia following, it seems to me that suturing of the different layers of muscle and fascia with the suture which I recently presented to the Society, may contribute something to the solution of this question.

DR. H. L. NICHOLS: In the case of gun-shot wound, I saw the patient several times in the after treatment and with Dr. Simmons, will say the result was excellent. Perhaps the recent aseptic treatment had very much to do with it. I do not wish to say anything in disparagement of the aseptic management of wounds, but I want to say there was some good treatment of that sort many years ago. I would call Dr. Simmons' attention to the case of an engineer who, 23 years ago, had the muscles of his left arm shattered, also sustaining a compound fracture. Dr. Simmons had the case, and treated it with wonderful results. That young man, after he left the Doctor's hands, went to work at his trade, as engineer, and followed it for years. I do not mean to say that the wound was not properly dressed, but that while years ago many did not practice aseptic surgery, we pursued what we believed to be cleanly work, and I do not believe that under the present system any result could have been better than the one I refer to as treated by Dr. Simmons.

Dr. Huntington: I am reminded of a case by the case mentioned by Dr. Briggs. The patient, when first seen, was suffering apparently from a violent attack of peritonitis. The whole trouble seemed to be in the stomach. The history of the case was this: For 10 or 12 years the man had had no action of the bowels without physic, and was obliged to use large doses for that purpose. I watched him through the attack and then dismissed him, telling him to go to work. He came to the Hospital again with a new obstructive trouble in the bowel. I put him to bed and examined him carefully with special reference to appendix trouble. I determined that the difficulty was in the descending colon. Before opening the abdomen this seemed to be in normal condition. In looking for a probable cause I fished out the appendix, and at first thought it was normal, but upon closer examination I discovered that the walls were thickened and soft, and that the cavity was filled with soft fecal matter. The appendix was ligated and removed, and the abdominal wound, which was in the mesial line, closed. He has been better since the operation, and says that for the first time in a long period he is free from the colicky pain which has troubled him for many years. This is an unusual case, and I believe I am correct in saying that while not in any great danger, he would very soon have been in jeopardy judging from the report of such cases that have been quoted by other authorities.

A Case in which 13 Feet of Intestine had been Dragged Through a Perforated Uterus and Torn Away from the Cecum.—**Dr. C. B. Nichols**: I wish to report a case which I think it would be well to place on record. A few weeks ago I was called suddenly to see a lady who was said to be in great danger. She had either performed an abortion on herself or else some one had done so for her. The fetus had been delivered, but the placenta remained in the cavity of the uterus. A physician was called, who discovered something protruding from the os, and, upon investigation, found it was an intestine. There was considerable hemorrhage and very severe pain, with the prospect of speedy death. She was removed to the "Ridge Hospital" at once. When I first saw her I found the pulse and respiration very rapid and a profuse hemorrhage from the vagina. As soon as possible, I opened the abdomen and found the uterus about the size of a five months pregnancy and very soft. The abdominal cavity was quite filled with blood. Upon lifting the uterus out of the pelvic cavity I discovered, on the posterior surface, just above the internal os, an opening in the uterus, through which passed a loop of small intestine. I immediately withdrew the intestine. The mesentery had been stripped entirely off. One end of the intestine had been torn from its attachment to the cecum. I inserted my finger into the cavity of the uterus and finding the placenta, delivered it, enlarging the opening. I cut off the intestine at the point where the mesentery stopped making a lateral anastomosis with the cecum on the opposite side. Thoroughly irrigating the cavity, I then closed the wound, finishing the operation by 6 P. M. I found that thirteen feet of the intestine had been drawn through the opening in the uterus. The patient died at 12:30 A. M., one remarkable feature being that she survived the injury and subsequent operative procedure for over eight hours.

Dr. J. H. Parkinson said that this case as an example of criminal ignorance could hardly be surpassed. It was simply inconceivable how such a state of affairs could have been brought about. The amount of force necessary to tear the intestine completely in two was very great, as could readily be demonstrated on the cadaver. It was also difficult to see what ten or twelve feet of intestine could be mistaken for. The speaker inquired who had signed the death certificate, as such a case seemed to demand an investigation.

Dr. Nichols said he understood the certificate had been signed by the Coroner, the cause of death being given as "abortion."

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, June 11, 1895.

The President, C. C. Wadsworth, M.D., in the Chair.

New Members.—Donald McC. Gedge, M.D., and F. W. Birdsall, M.D., were duly elected members of the Society.

Specialists' Treatments that may be Successfully Employed by the General Practitioner.—DR. P. M. JONES read a paper upon this subject. He said it was impracticable for the general practitioner to use the ophthalmoscope, but a small mirror and a 2-inch focus lens will be of much service to any physician, as with this the conditions of the media can be readily noted. In the removal of foreign bodies from the cornea any sharp instrument is to be avoided in untrained hands. A piece of blotting paper will often suffice, and a small stick whittled to a broad flat point, will dislodge the more firmly embedded particles. Ulceration of the cornea and conjunctiva in strumous children should be treated according to the general condition of the patient; the nose, which frequently presented a highly irritated mucous membrane, should also not be neglected. Locally, he advised atropine solution (2 or 3 grains to the ounce), the conjunctiva being touched with a solution of nitrate of silver (5 or 10 grains) once a day. The two eye diseases the general practitioner will most commonly meet, and which, if promptly recognized and energetically treated, can generally be cured, are glaucoma and ophthalmia neonatorum. Unfortunately, neither of these conditions were, as a rule, promptly diagnosed. Any conjunctivitis in a new-born infant should be at once regarded with suspicion, and a 2 per cent. nitrate of silver solution should be promptly instilled, the eyes being thoroughly cleansed every few hours with an antiseptic solution. Cleanliness is the most important element in the treatment of these diseases. Almost every case of glaucoma could be saved were it taken in hand sufficiently early. In almost every case of biliousness, or sick headache, or disturbed vision, it may be said, suspect glaucoma. Prompt instillation of a 1 or 2 per cent. pilocarpine solution, or eserine (1 to 5 grains) is demanded. In all examinations of the ear, nose, and throat the head mirror will be found a very necessary instrument. By this means foreign bodies or accumulations of secretion in the nose and ear can be readily recognized. Deafness in children should always direct attention to the throat, where, in a large majority of cases, the tonsils will be found much enlarged, while adenoid vegetations are found present. Many cases of so-called "snuffles" in children could be satisfactorily treated by the general practitioner. These cases were often diagnosed as colds, and correspondingly neglected. There were also syphilitic conditions of the nose and pharynx that could be readily recognized by examination and that were amenable to treatment.

DR. G. W. DAVIS said: The routine practice of instilling a 2 per cent. nitrate of silver solution into the eyes of the new-born, he could hardly endorse as a preventive measure. It did not seem to be a scientific procedure. In recent years it had been his practice to thoroughly cleanse the eyes with a 3 or 4 per cent. boracic acid solution. He agreed with Dr. Jones that the general practitioner should be familiar with diagnostic instruments, as he generally saw those cases in the early stages, and could thus recognize when they were getting beyond his control, when they could be referred to the specialist.

DR. M. C. O'TOOLE said: Practical papers of this kind were of the greatest utility. He believed the time had arrived when the general practitioner, without the ophthalmoscope, is minus the most efficient instrument in diagnosis. The speaker had always taken the opportunity of impressing this upon physicians.

DR. K. PISCHL said: The early recognition of glaucoma was most important, the disease often coming to the specialist when it was too late. The too frequent and promiscuous dropping of atropine solution into the eye is a dangerous thing. Quite often this was done when eserine or pilocarpine should have been used. For the removal of foreign bodies from the conjunctiva, a toothpick wrapped with cotton and passed over the eyeball, acts as a hook, readily dislodging the obstruction.

DR. M. KROTOSZYNER thought the specialists made a mistake in paying too much attention to treatment. Our efforts should be concentrated on making a diagnosis so as to secure a better basis to work upon. In this respect, he observed the author took it for granted that his hearers were all diagnosticians. Every practitioner should be able to use the ophthalmoscope, and the physician who was competent enough to treat corneal diseases should be able to diagnose albuminuric retinitis. The differential diagnosis between syphilitic ulceration of the throat was a difficult matter, and in order to treat it correctly it was necessary to first make a diagnosis.

Dr. D. W. Montgomery said: Dr. Krotoszyner is right in many respects; too much stress is laid on treatment now-a-days. We see whole journals devoted to small notes on treatment, no mention being made of diagnosis. This is certainly not conducive to medical advancement.

Dr. C. G. Kuhlman said: The paper did not strictly come within the scope of the specialist, but rather within that of the general practitioner.

Dr. Jones in replying said: There can be no doubt of the great benefit of a 2 per cent. nitrate of silver solution in the prevention of ophthalmia neonatorum. Credé's results had certainly demonstrated this to the most skeptical. The preceding is not unscientific; there is no pain, only slight redness, and within twelve hours the eye is practically in a normal condition. The speaker said he had assumed in his paper that the constitutional treatment of syphilis would be always carried on no matter what local conditions would be assumed. The matter of diagnosis had not been considered, as this did not come within the scope of the paper. He only desired to make some reference to the early recognition of glaucoma and to the differential diagnosis between tubercular and syphilitic ulceration of the throat, it would take quite a long time to note all the points.

SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

Regular Meeting, June 3, 1895.

L. C. Lane, M.D. in the Chair.

Dr. W. F. Southard read a paper entitled "Spectacles, and Who Shall Prescribe Them."

Dr. K. Pischl said it had been brought out so clearly that the oculist is the proper one to prescribe glasses, that he only desired to repeat it.

Dr. Stanley Stillman said there can be no question as to the stupidity of people having the optician fit them with glasses. To mention one of the more simple errors; the amount of latent hypermetropia present in a case may be of the greatest importance, and the optician does not take it into account. He was glad the subject had been brought up and he wished some one would bring up the subject of counter prescribing on the part of druggists and a few similar abuses. It is only through repetition of agitation of this kind that the public can be made to appreciate that it is to its interest to secure the best medical opinion posible in every given case.

Dr. R. L. Rigdon said: If we are to begin educational work on this line it would be well to begin with the doctors. Many patients go to the opticians to have glasses fitted on the advice of the general practitioner.

Dr. L. C. Lane said he had had an interesting experience many years ago. A young man came to him who had beautiful eyes, but who could not see well. He had consulted many physicians, and had a pair of glasses. One doctor told him he would finally have to lose one eye. Dr. Lane persuaded him to go to Donders. He got as far as Boston, where friends advised him to go to Dr. Williams. By the merest accident, he found the trouble was that one of the lenses of his spectacles had been put in the frame upside down. He referred to an address by Moleschott to Donders. Certainly, Donders was one of the greatest benefactors of our race.

SPECIAL CORRESPONDENCE.

GERMANY.

[FROM OUR OWN CORRESPONDENT.]

The Diet of German Physicians.—Reform of Medical Clubs.—The Aerztekammern.—A Strange Decision.—An Ill-Conducted Asylum.—The Procession of Echternach —Behring's Heilserum.—Death of Professors Ludwig and Thiersch.

June 28th and 29th the "Deutscher Aerztetag" or Diet of German Physicians, was assembled at Eisenach, that ancient city, famous chiefly because of the Wartburg, the castle which was the refuge of Martin Luther after he had renounced his allegiance to Rome. This medical parliament consists of the delegates of all those associations of practitioners that belong to the "Aerztevereinsbund," *i. e.* union of medical associations, and mustered on this occasion some 117 strong, representing about 11,000 medical constituents. The union accepts as participants all purely medical societies numbering not less than 25 members, and the great majority of all practitioners in Germany are thus enrolled. A council, which is elected annually, but which is, in reality, almost a permanency, as the same members are generally reëlected by an overwhelming majority, conducts the business in hand, edits the *Vereinsblatt*, the official organ of the union; takes charge of the finances, etc. For several years the office of President has been filled by Dr. Graf; for the time being, a Vice-President of the Prussian Landtag, and a man to whom we all owe a deep debt of gratitude for his untiring devotion and thoughtful energy. Although devoid of any executive authority, the Aerztetag has, during the 23 years of its existence, done a great deal towards the furtherance of the interests of the profession in general. This year, the two chief subjects under discussion were the relations between the faculty and the life insurance companies, and the working of the laborers' medical clubs.

The latter question has become of vital importance, for in consequence of the law passed by the Reichstag a few years ago, no less than four-fifths of the whole population of the realm are now members of clubs paying their medical attendants at the rate of about 6 to 8 cents a visit, and the income of the profession, as a whole, has been reduced by several millions of marks yearly, according to the statements in the journal. Such a state of affairs would not be possible if it were not for the great superfluity of young doctors willing to accept a club appointment at almost any salary, with consequent unlimited underbidding on the one hand, and for the attitude of the government, that for the last generation has done little or nothing to benefit us (except, perhaps, the permission to found the Chambers of medical deputies, of which more anon) on the other. Indeed, Herr von Bötticher, Secretary of State, propounds the opinion that these clubs being instituted for the welfare of the people and the realm, the medical profession is to be considered bound to waive their self-interests and do a large amount of hard, unpleasant work quite gratuitously for the good of mankind in general.

To remedy this disastrous and increasing evil, an attempt was made in Berlin two or three years ago to put a stop to this underbidding for appointments, by doing away with the latter entirely. An association was formed calling itself the "Verein der freigewählten Kassenärzte," or the club doctors with unrestricted selection, meaning that members of the respective clubs may call in whatever doctor they choose. The principal by-laws are as follows: the clubs agree to employ as medical advisers only the members of said association, which, by the way, now numbers about 700. All qualified, reputable practitioners resident in or about the city, who are willing to attend club members at the rate fixed upon, are admitted, without further conditions, to the association. Physicians acting contrary to the interests of the clubs (prescribing in too costly a manner, encouraging malingerers, etc ,) can be excluded only by a decree of their colleagues, though the clubs have the right in notorious cases to make a decisive demand in this respect. The money that the clubs pay as salary for medical advice is increased a trifle, and is divided quarterly, according to the number of visits, operations and so forth, that each doctor has entered on his account. This method has already given excellent results. The workmen are far better satisfied with their treatment than formerly; the expenses of the clubs are not enhanced, in consequence of increased care in prescribing, in putting down malingerers, etc; and there is no necessity for the doctor to fawn on the members of the club-boards, as all appointing goes through the hands of the council of the association. A powerful majority, representing about 9,000 votes to 1,000, declared itself in favor of this method, so we may hope that soon other towns will follow the example so well set by the metropolis.

Besides the Aerztetag, we have in Germany, the Chamber of Medical Deputies, that I just mentioned, the "Aerztekammern." These Kammern, of which each province has one, were founded under the administration of the former minister, von Gossler, and consist of about 20 members, elected by the votes of all practitioners resident in that particular province, irrespective of their being members of an association or not. These bodies also have merely the right of discussion and of making petitions. The only approach to executive powers is the formation of a court of honor, before which cases of misbehavior and disloyal conduct may be brought. But, as the severest punishment which can be inflicted is the withdrawal of the right to vote at the polling for the chambers, these courts are almost entirely powerless to combat just the very worst elements in the profession.

A curious example of this kind occurred quite lately in Berlin. A fully qualified physician entered into partnership with a certain Mr. Glünicke, a lawyer, who has forsaken his original calling for the more profitable occupation of an herbalist or, as they call themselves here, a "Naturarzt" or physician who cures by Nature's remedy only—as if the regular doctor used supernatural, or, anyhow, unnatural means However, the name is attractive, and as no trouble or money was spared in advertising and lecturing the specialty in public, a certain juice of herbs, which is alleged to cure all ailments of every kind whatsoever, had a rapid sale, and the business was highly remunerative. The medical association of Berlin, presently took notice of these proceedings, and declared the doctor's conduct infamous, especially, as in a few cases, the patients had suffered palpable detriment to their health in consequence of their having been thus induced to neglect employing the proper and indispensable remedies for their particular disorder. The offending practitioner was expelled from the association, but there is no possibility of preventing him from continuing to practise as before And what is worst of all, the military authorities on being informed of the facts, as this man is assistant surgeon and therefore an officer in His Majesty's army, declared that they saw no reason to commence proceedings against him. Truly, a passing strange decision as to the duty of a physician and an officer; or, in fact, of any honorable and truth-loving gentleman.

Great indignation was also aroused, both in the laity and the medical profession, by the astonishing revelations which the recent proceedings in the law courts at Aix la Chapelle brought to light regarding the condition of things at the lunatic asylum at Mariaberg, which is, or was hitherto, in charge of the Brothers of the Order of St. Alexis. Originally, this institution was founded, like the other homes belonging to the Order, on quite a small scale, for the reception of epileptics and others suffering from minor mental disorders. Evidently, good work was performed, for in course of time the number of the patients admitted increased to several hundreds. The monks, however, had almost entire charge of them, for the two physicians attached to the home were non-resident, spending only an hour or two daily there, a space of time utterly inadequate to the wants of the sufferers, for in course of time, not only simpler cases, but all kinds of aliens were received. Now, it occurred that a certain Scottish Catholic priest, Mr. Forbes, was by order of his superiors detained there for three years and a quarter, on the alleged ground of his being of unsound mind. A somewhat vague certificate was obtained from the Medical Officer of Health, to the effect that it was advisable to detain Mr. F. for the purpose of observation as to his mental condition for a while. This "period of observation" was protracted over 39 months, during which time the unhappy prisoner, for such he really was, never had a chance of proving his saneness to the doctors, although a quite superficial examination would have shown (as was proved by first-class expert testimony at the trial) that there was, indeed, no reason to shut him up in an asylum. Ultimately he succeeded in regaining his freedom through the intervention of an hotel-keeper at Iserlohn—Mr. Mellage. This gentleman subsequently published a pamphlet, for which Mr. Forbes supplied detailed information, and in which, although himself a member of the Catholic church, he unreservedly attacked the administration of the institution. The cloister entered proceedings against Mr. Mellage, but at the trial it was shown that his assertions were even more than perfectly correct, and the defendant, as it were, changed parts with the plaintiffs. By the testimony of former attendants and inmates it was conclusively proved that it was quite customary at Mariaberg to reduce refractory patients to order by beating them on the head with a bunch of heavy keys, knocking them down, kicking them, ducking them in a trough especially prepared for the purpose, until they were nearly suffocated, or even keeping them tied to a tree for several hours or a day. Strange to say the medical superintendent, A. Cappelmann, seemed to have no knowledge of the manner in which things were conducted under this regime. He had, even, just two years ago at the meeting of German alienists at Frank-fort, spoken and written in strong terms in defence of these lay asylums which had been forcibly attacked by his *confrères* on that occasion as being utterly inadequate and out of date. A resolution was, however, almost unanimously adopted by the assembly to the effect that no physician should accept an appointment at any such institution where the directorship and final authority is vested in the hands of non-medical persons. The justice of this postulate has now become still more apparent by these deplorable occurrences in an institution which has hitherto posed as one of the best in the land.

In other respects, too, it seems as if in this corner of the realm on the borders of Holland and Belgium, the spirit of the middle ages has not yet died out. In Treves but a few years ago the veritable coat of Christ was placed on view, and hundreds of thousands flocked to see it, many of the pilgrims positively worshiping the relic as if it were something supernatural. And a similar reminiscence of former times may be witnessed each year at Whitsuntide in Echternach in Luxemburg, which is just on the other side of the frontier, and more than half German. This procession was originated in the fifteenth century; it is reported to obtain relief from an epidemic of St. Vitus' dance, as chorea is here named, which had broken out. The rule for the participants is that they have to make two steps backward for every three steps forward; and to the present day a great number of the more ardent believers perform this peculiar march right through the town, taking three or four hours to complete it. They are assisted by music of a monotonous character, to which words have been found commencing with the unwarranted assertion, "Adam seven sons had gotten." If this is a digression, I think it will be pardoned on account of the peculiarly interesting psychological side of the question.

As to medicine proper, the treatment of diphtheria by Behring's antitoxin is still the subject which engrosses most attention, and although the aim proposed of stamping out this disease in the same manner as has, to all intents, been the case with small-pox, is still far from being realized, the results published on all sides show so great an improvement generally, as compared with other methods of treatment, that one cannot doubt the fact that this remedy marks a distinct advance in therapeutics. At the meeting of physicians at Munich this spring it was universally acknowledged that far better results are now obtained than formerly, and since then the reports published are nearly all to the same effect. The newest publication is an exhaustive review of Prof. Baginsky, who also confirms these observations.

A severe loss has been sustained by the University of Leipzig through the deaths of two of its most eminent medical members—Carl Ludwig and Carl Thiersch, in rapid succession. These are men who have left their mark in the world. It is unnecessary for me to speak of their achievements, for these are well known all the world over. In America, I believe, Ludwig especially is known to many, even personally; a tall, somewhat awkward-looking man he was, with a clean-shaven face, and in general something of the appearance of a country parson. In fact, he used to relate with much satisfaction a little anecdote that once at a watering place he was accosted by a party of clergymen who took him for a brother in office until he put them to flight by remarking, "Gentlemen, you are mistaken, I am not a minister, I am simply a teacher." Thiersch had even still more sense of humor, and nobody who has attended his clinic will forget his caustic utterances and sarcastic remarks to the unlucky students who happened to display a defective understanding of the subjects they were supposed to have studied.

JULY 5, 1895.

REVIEWS AND NOTICES.

LOCAL ANESTHETICS AND COCAINE ANALGESIA; THEIR USES AND LIMITATIONS. By Thomas H. Manley, A. M., M.D., New York, member of the New York Academy of Medicine and of the New York Pathological Society: J. H. Chambers & Co., St. Louis. pp. 184. Price, $1.50.

This work covers quite fully the field of local anesthesia. In the plan of the work, general considerations are first touched upon, together with a discussion of the various means of producing local anesthesia. The second part of the book is devoted to cocaine and its uses. The *technique* of its administration is given minutely, together with a detailed account of the various minor and major operations in which it may be used. The author demonstrates that its field of usefulness is quite broad. While the book is on the whole interesting and instructive, there are a number of points about intradermic injections and the anasthetic action of other drugs than cocaine when used hypodermically, that are not touched upon. Again, as an example of crude proof reading, the book is a curiosity. Nearly every page shows one or more oversights. Among them may be noted "dolerous sentation," "notabley," "in grawn toe nail," "exhilaration," "sensability," etc. The so-called index is not an index at all, but is a simple enumeration of the subjects treated of, arranged not alphabetically, but according to the page, and should have been placed in the table of contents. There is really no excuse for placing such a crudely printed book before an intelligent profession.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held July 2, 1895, the following were granted certificates to practise medicine in this State:

Christo Petroff Balabanoff, Tacoma, Wash.; Med. Dept. Univ. City of New York, March 6,'88.
J. K. Dubois, San Francisco; St Louis Med. Coll., Mo., March 12,'75.
I. C. Fisher, Garvanza; Med. Coll. of Indiana, Feb. 28,'84.
Wm. Freeman, San Diego; Med. Coll. of Indiana, Feb. 28,'77.
Emanuel Goodman, San Francisco; Med. Coll. of Ohio, April 7,'92.
Louis H. Grunig, Winters; Hosp. Coll. of Med., Ky., June 18,'95.
Agnes Haviland, Oakland; Ensworth Med Coll., Mo., March 31,'93.
Clarence M Haviland, Los Angeles; Coll. of Med. Univ. So. Cal., June 1,'94.
Peter Janss, Los Angeles; Bellevue Hosp. Med. Coll., N. Y., March 9,'85.
E. A Kelley, Oakland; Med. Coll. of Ohio, Feb 27,'78.
John V. Larzalere, Chula Vista; Med. Dept. Univ. Buffalo, N. Y., Feb. 26,'84.
Oscar B. Lowentrout, Riverside: Jefferson Med. Coll., Pa., May 15,'95.
Frank H. McNeel, Santa Rosa; Rush Med. Coll., Ill., Feb 22,'81.
Charles Robert Nelson, Auburn; Western Univ. of Pennsylvania, March 21,'95.
Frances L. Newton, Woodland; Woman's Med. Coll. of Pa., May 8,'95.
Edward A. Scott, Coronado; Coll. Phys. and Surgs., N. Y., June 10,'91.
Franklin Smith, San Francisco; Med. Dept Univ City of New York, March 3,'65.
Charles E. Winslow, Los Angeles; Rush Med. Coll., Ill., Feb. 21,'82
F. E. Yoakum, Garvanza; Hosp. Coll. of Med., Ky., June 16,'85.

REFUSED:

Emma W. Stever, Florence, Cal.; insufficient credentials.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific) from June 20, 1895, to July 20, 1895.

Leave of absence for one month, to take effect on or about the 23d inst., is granted Lieut.-Col. Johnson V. D. Middleton, Deputy Surgeon General. Par. 4, S. O. 85, Dept. of California, July 2, 1895.

Captain Adrian S. Polhemus, Assistant Surgeon, granted leave of absence for two months, to take effect after his return to his proper station, Fort Douglas, Utah, and at such time thereafter as his services can be spared by his Post Commander.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service (District of the Pacific) from June 20, 1895 to July 20, 1895.

John Godfrey, Surgeon, detailed as Chairman, Board for Physical Examination, Candidates Revenue Cutter Service, June 17, 1895.

Rupert Blue, Assistant Surgeon, detailed as Recorder, Board for Physical Examination, Candidates, Revenue Cutter Service, June 17, 1895.

ITEMS.

Dr. T. D. Ross has removed from Shoshone, Idaho, to Ferndale, Cal,

Dr. H. Kreutzmann has removed from 913 to 1018 Sutter street, San Francisco.

Dr. M. L. Pettit has removed from 1420 to 1354 Howard street, San Francisco, Cal.

Dr. T. B. Goodspeed, formerly of Galt, Cal., and more recently of Seattle, Wash., having spent about 18 months in Europe, has decided to settle permanently in Chicago. The Doctor's address for the present will be 269 Dearborn street.

Dr. Geo. B Somers, late Police Surgeon at the San Francisco Receiving Hospital, sails for Japan and China on August 13th, as Surgeon of the S. S. "China," P. M. S S. Co. The Doctor will return about Oct. 13th, and will resume practice in San Francisco.